

**SCRUTINY BOARD
(ADULT SOCIAL SERVICES,
PUBLIC HEALTH, NHS)**

21 FEBRUARY 2017

**UPDATE ON DEVELOPMENT OF THE LEEDS
SUSTAINABILITY AND TRANSFORMATION PLAN**

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Leeds Health & Wellbeing Board

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Report of: Matt Ward (Chief Operating Officer, Leeds South and East CCG)

Report to: The Leeds Health and Wellbeing Board

Date: 06 September 2016

Subject: Update on Development of the Leeds Sustainability and Transformation Plan (STP)

Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If relevant, Access to Information Procedure Rule number:		
Appendix number:		

Summary of main issues

In October 2014, the NHS published the Five Year Forward View, a wide-ranging strategy providing direction to health and partner care services to improve outcomes and become financially sustainable. On December 22nd, NHS England (NHSE) published 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21' which described the requirement for identified planning 'footprints' to produce a Sustainability and Transformation Plan (STP) as well as linking into appropriate regional footprint STPs (at a West Yorkshire level).

The planning guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the NHS Five Year Forward View. STPs are 'place-based', multi-year plans built around the needs of local populations and should set out a genuine and sustainable transformation in service user experience and health outcomes over the longer-term.

Rob Webster, Chief Executive of South West Yorkshire Partnership NHS Foundation Trust, has been appointed by NHSE as the lead for the West Yorkshire STP, with Tom Riordan, Chief Executive of Leeds City Council, as the Senior Responsible Officer for the Leeds STP.

NHSE requested that regional STP footprints deliver their initial STPs at the end of June 2016. An initial STP for West Yorkshire was duly submitted. However, NHSE has

recognised that further work is required for all STPs and has agreed a continued planning phase up to October.

This paper provides an overview of the STP development in Leeds and at a West Yorkshire level so far, and highlights some of the areas that will be addressed in the final Leeds and West Yorkshire STPs once they are developed in the autumn.

The paper also makes reference to the Local Digital Roadmaps (LDR) which, alongside the development of the STPs, are a national requirement. The LDR is a key priority within the NHS Five Year Forward View and an initial submission for Leeds was provided to NHSE at the end of June. This outlines how, as a city, we plan to achieve the ambition of being “paper-free at the point of care” by 2020 and demonstrates how digital technology will underpin the ambitions and plans for transformation and sustainability. A paper covering the LDR in greater detail is also shared and discussed at the September 6th Health and Wellbeing Board.

Recommendations

The Health & Wellbeing Board is asked to:

1. Consider – does it endorse the approach described within this paper for the continued development of the Leeds and West Yorkshire STPs, within the nationally prescribed framework?;
2. Note the key areas of focus for the Leeds STP described in this report and how they will contribute to the delivery of the Leeds Health and Wellbeing Strategy;
3. Note that the Leeds Health and Wellbeing Board will continue to provide a strategic lead for the Leeds STP;
4. Note the key milestones outlined in this paper and the officers from the Leeds health and care partnership who are leading the development of the Leeds STP and the West Yorkshire STP;
5. Receive a further report in November 2016 with an overview of the proposed key changes and impacts outlined in the Leeds STP and the West Yorkshire STP as we move forward towards implementation and oversight.

1 Purpose of this report

- 1.1 The purpose of this paper is to provide the Health & Wellbeing Board with an overview of the emerging Sustainability and Transformation Plans (STPs).
- 1.2 It provides an update to the paper discussed at the April 21st Health and Wellbeing Board setting out the background, context and the relationship between the Leeds and West Yorkshire plans. It also highlights some of the key areas that will be addressed within the Leeds plan which will add further detail to the strategic priorities set out in the recently refreshed Leeds Health and Wellbeing Strategy 2016 – 2021.
- 1.3 The paper seeks assurance from the Board that it supports the approach being taken.

2 Background information

Local picture

- 2.1 Leeds has an ambition to be the Best City in the UK by 2030. A key part of this is being the Best City for Health and Wellbeing and Leeds has the people, partnerships and placed-based values to succeed. The vision of the Leeds Health and Wellbeing Strategy is: 'Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest'. A strong economy is also key: Leeds will be the place of choice in the UK to live, for people to study, for businesses to invest in, for people to come and work in and the regional hub for specialist health care. Services will provide a minimum universal offer but will tailor specific offers to the areas that need it the most. These are bold statements, in one of the most challenging environments for health and care in living memory.
- 2.2 Since the first Leeds Health and Wellbeing Strategy in 2013, there have been many positive changes in Leeds and the health and wellbeing of local people continues to improve. Health and care partners have been working collectively towards an integrated system that seeks to wrap care and support around the needs of the individual, their family and carers, and helps to deliver the Leeds vision for health and wellbeing. Leeds has seen a reduction in infant mortality as a result of a more preventative approach; it has been recognised for improvements in services for children; it 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 the most deprived wards.
- 2.3 These are achievements of which to be proud, but they are only the start. The health and care system in Leeds continues to face significant challenges: the ongoing impact of the global recession and national austerity measures, together with significant increases in demand for services brought about by both an ageing population and the increased longevity of people living with one or more long term conditions. Leeds also has a key strategic role to play at West Yorkshire level, with the sustainability of the local system intrinsically linked to the sustainability of other areas in the region.
- 2.4 Leeds needs to do more to change conversations across the city and to develop the necessary infrastructure and workforce to respond to the challenges ahead. As a city, we will only meet the needs of individuals and communities if health and care workers and their organisations work together in partnership. The needs of patients and citizens are changing; the way in which people want to receive care is changing, and people expect more flexible approaches which fit in with their lives and families.
- 2.5 Further, Leeds will continue to change the way it works, becoming more enterprising, bringing in new service delivery models and working more closely with partners, public and the workforce locally and across the region to deliver shared priorities. However, this will not be enough to address the sustainability challenge. Future years are likely to see a reduction in provision with regard to services which provide fewer outcomes for local people and offer less value for the 'Leeds £'.

- 2.6 Much will depend on changing the relationship between the public, workforce and services. There is a need to encourage greater resilience in communities so that more people are able to do more themselves. This will reduce the demands on public services and help to prioritise resources to support those most at need. The views of people in Leeds are continuously sought through public consultation and engagement, and prioritisation of essential services will continue, especially those that support vulnerable adults, children and young people.

National picture

- 2.7 In October 2014, the NHS published the Five Year Forward View, a wide-ranging strategy providing direction to health and partner care services to improve outcomes and become financially sustainable. On December 22nd, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21', which is accessible at the following link:

<https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>

- 2.8 The planning guidance asked every health and care system to come together to create their own ambitious local blueprint – Sustainability and Transformation Plan (STP) - for accelerating implementation of the Five Year Forward View and for addressing the challenges within their areas. STPs are place-based, multi-year plans built around the needs of local populations ('footprints') and should set out a genuine and sustainable transformation in service user experience and health outcomes over the longer term. The key points in the guidance were:

- The requirement for 'footprints' to develop a STP;
- A strong emphasis on system leadership;
- The need to have 'placed based' (as opposed to organisation-based) planning;
- STPs must cover all areas of Clinical Commissioning Group (CCG) and NHS England commissioned activity;
- STPs must cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies;
- The need to have an open, engaging and iterative process clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards;
- That STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

- 2.9 The national guidance is largely structured around asking areas to identify what action will take place to address the following three questions:
- *How will you close your health and wellbeing gap?*
 - *How will you drive transformation to close your care and quality gap?*
 - *How will you close your finance and efficiency gap?*
- 2.10 NHSE recognises 44 regional ‘footprints’ in England. This includes West Yorkshire. The West Yorkshire footprint in turn comprises 6 ‘local footprints’, including Leeds (the others being Bradford and Craven, Calderdale, Kirklees, Harrogate & Rural District and Wakefield). There is an expectation that the regional STPs will focus on those services which will benefit from planning and delivery on a regional scale while local STPs will focus on transformative change and sustainability in their respective local geographies. Local STPs will also need to underpin the regional STP and be synchronised and coordinated with it.
- 2.11 The following describes the emerging West Yorkshire STP as well as the Leeds STP which will allow Leeds to be the best city for health and wellbeing and help deliver significant parts of the new Leeds Health and Wellbeing Strategy. Both STPs should be viewed as evolving plans which be significantly developed through July – October 2016 for delivery from November onwards. In addition, a formal update on the West Yorkshire STP has been prepared by the West Yorkshire STP Programme Management Office; this is attached as an appendix.
- 2.12 Key milestones
- December 2015 – planning guidance published
 - 15th April 2016 - Short return to NHSE, including priorities, gap analysis and governance arrangements
 - May – June development of initial STPs
 - End June – Each regional footprint (including West Yorkshire) submitted its emerging STP for a checkpoint review
 - July – October – further development of the STPs, at both Leeds and West Yorkshire levels, and active engagement with citizens, service users, carers and staff on the right solutions to address the gaps
 - October – aim to have final STPs prepared for review and approval
 - November onwards – delivery and implementation of the STPs.

3 Main issues

'Geography' of the STP

- 3.1 NHSE has developed the concept of a 'footprint' which is a geographic area that the STP will cover and have identified 44 'footprints' nationally.
- 3.2 Leeds, as have other areas within West Yorkshire, made representation regionally and nationally that each area within West Yorkshire should be recognised as its own footprint. However, since April it has become clear that STP submissions to NHS England will be made only at the regional level ie, for us, a West Yorkshire STP which is supported by 6 "local" STPs, including the Leeds STP.
- 3.3 The emerging STPs for Leeds and West Yorkshire will therefore be multi-tiered. The primary focus for Leeds is a plan covering the Leeds city footprint which will focus on citywide change and delivery. It will sit under the refreshed Leeds Health and Wellbeing Strategy and will encompass all key health and care organisations in the city. When developing the Leeds city STP, consideration will be given to appropriate links / impacts at a West Yorkshire level.

Approach to developing the West Yorkshire STP

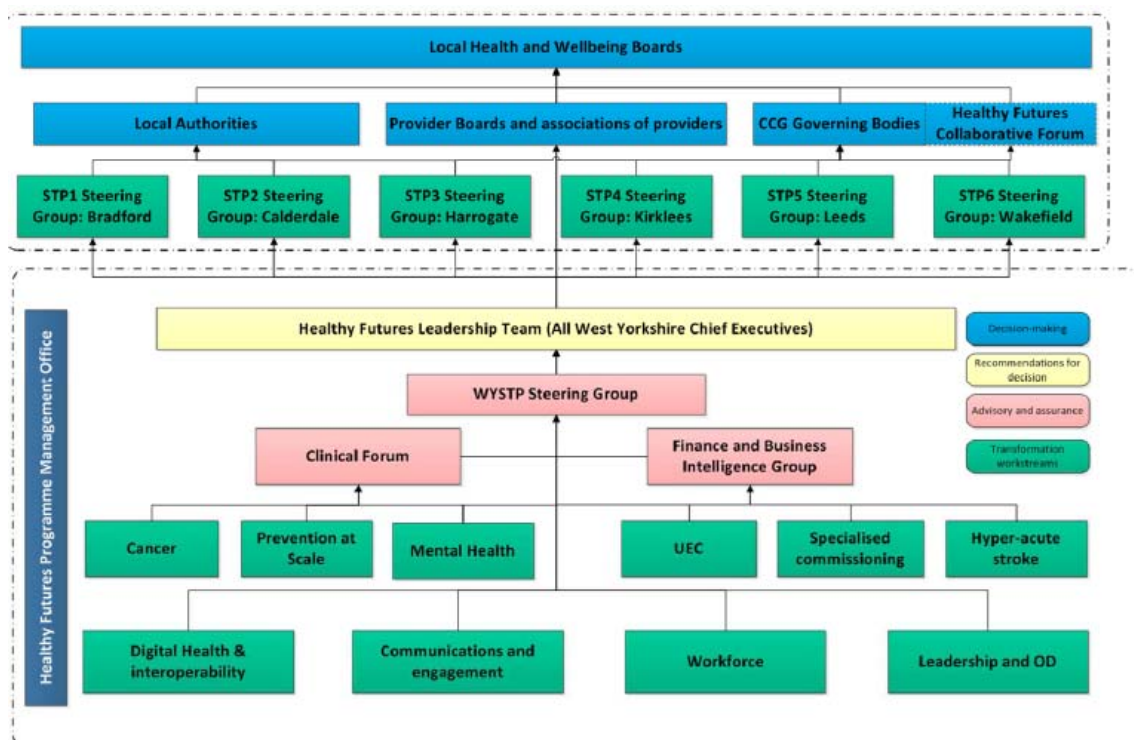
- 3.4 Rob Webster, Chief Executive of South West Yorkshire Partnership NHS Foundation Trust, has been appointed by NHSE as the lead for the West Yorkshire STP and the Healthy Futures Programme Management Office (hosted by Wakefield CCG) is providing support to the development of the West Yorkshire STP.
- 3.5 Developing the West Yorkshire STP was the substantial agenda item of the West Yorkshire Collaboration of Chief Executives meeting held on 8th April. At that meeting, it was agreed that 'primacy' should be retained at a local level and any further West Yorkshire priorities will be determined by collective leadership using the following criteria:
- *Does the need require a critical mass beyond a local level to deliver the best outcomes?*
 - *Do we need to share best practice across the region to achieve the best outcomes?*
 - *Will working at a West Yorkshire level give us more leverage to achieve the best outcomes?*
- 3.6 The following guiding principles will underpin the West Yorkshire approach to working together:
- *We will be ambitious for the populations we serve and the staff we employ*
 - *The West Yorkshire STP belongs to commissioners, providers, local government and NHS*

- *We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict*
- *We will undertake shared analysis of problems and issues as the basis of taking action*
- *We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.*

3.7 Priority areas currently being considered at a West Yorkshire STP level include: Urgent & Emergency Care, Specialised Commissioning, Mental Health, Prevention at Scale, Stroke, and Cancer

3.8 These areas will be supported by enabling workstreams covering: digital, workforce, leadership and organisational development, communications & engagement and finance & business intelligence.

3.9 The following diagram shows the framework for the development of the West Yorkshire STP.



3.10 Leeds is well represented within the development of the West Yorkshire STP with Nigel Gray (Chief Executive, Leeds North CCG) leading on Urgent and Emergency Care, Phil Corrigan (Chief Executive, Leeds West CCG) leading on Specialising Commissioning, Dr Ian Cameron (Director of Public Health, Leeds City Council) leading Prevention at Scale, Jason Broch (Chair of Leeds North CCG) leading on Digital, and Dr Andy Harris (Clinical Chief Officer Leeds South and East CCG) leading on Finance and Business Intelligence. In addition, Julian Hartley (Chief Executive, Leeds Teaching Hospitals NHS Trust) is chair of the West Yorkshire Association of Acute Trusts (WYAAT) and Thea Stein (Chief

Executive of Leeds Community Healthcare NHS Trust) is the co-chair of a new West Yorkshire Primary Care and Community Steering Group.

- 3.11 A series of workshops have been arranged focusing on the different priority areas for West Yorkshire with representatives from across the CCGs, NHS providers and local authorities in attendance.
- 3.12 It is important to recognise that at the time of writing this paper the West Yorkshire STP is still in its development stage and the links between this and the six local STPs are still being worked through.
- 3.13 Leeds is also taking a lead role in bringing together Chairs of the Health and Wellbeing Boards across West Yorkshire to provide strategic leadership to partnership working around health and wellbeing and the STPs across the region.

Approach taken in Leeds

- 3.14 The refreshed Joint Strategic Needs Assessment (JSNA), the development of our second Leeds Health and Wellbeing Strategy and discussions / workshops at the Health and Wellbeing Boards in January, March, April, June and July have been used to help identify the challenges and gaps that Leeds needs to address and the priorities within our Leeds STP. The Health and Wellbeing Board has also provided strategic steer to the shaping of solutions to address these challenges.
- 3.15 Any plans described within the final Leeds STP will directly link back to the refreshed Leeds Health and Wellbeing Strategy under the strategic leadership of the Health and Wellbeing Board.
- 3.16 The Leeds Health and Care Partnership Executive Group (PEG) has been meeting monthly to provide oversight of the development of the Leeds STP. This group comprises the Chief Executives / Accountable Officers of the statutory providers and commissioners, the Director of Adult Social Care, the Director of Children's Services and the Director of Public Health, chaired by the Chief Executive of Leeds City Council.
- 3.17 A joint team with representatives from across the statutory partners is driving the development of the Leeds STP while ensuring appropriate linkages with the West Yorkshire STP. This team is being led by the Chief Operating Officer, Leeds South and East CCG. It comprises:
- A Central Team, providing oversight, programme management, coordination, financial and other impact analysis functions;
 - Senior Managers and Directors across key elements of health and social care, who are responsible for identifying the major services changes we need to address the gaps;
 - Experts from the “enabling” parts of the system such as informatics, workforce and estates, who need to address the implications of, and opportunities arising from, the proposed service changes;

- Individual members of the PEG, who act as Senior Responsible Owners and champion specific aspects of the STP;
- A City-wide Planning Group, with representation from across the city, which provides assurance to the PEG on STP development.

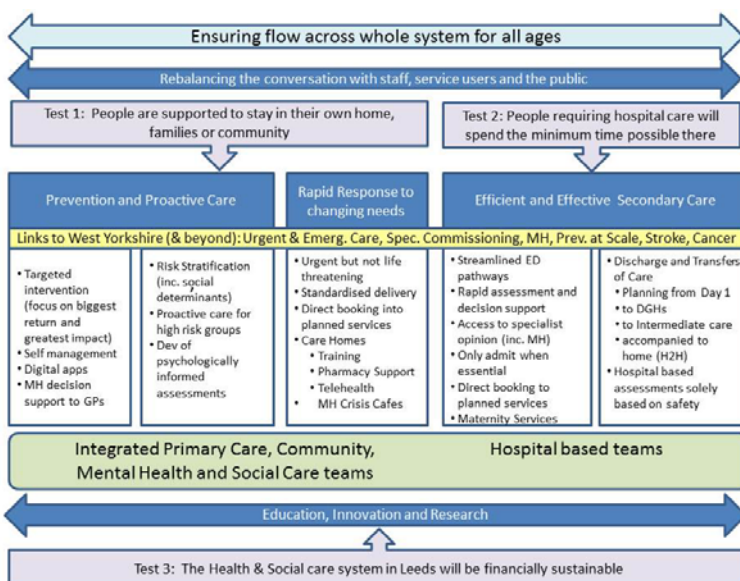
3.18 The development of the Leeds STP has initially identified 5 primary ‘Elements’. These are the areas of health and care services where we expect most transformational change to occur:

- ‘Rebalancing the conversation’ (sometime referred to as ‘the social contract’) with staff, service users and the public;
- Prevention and Proactive Care;
- Rapid Response in Time of Crisis;
- Efficient and Effective Secondary Care;
- Education, Innovation and Research.

3.19 These are supported by the ‘enabling aspects’ of services / systems – where change will actually be driven from:

- Workforce
- Digital
- Estates and Procurement
- Communications & Engagement
- Finance & Business Intelligence.

These emerging themes are illustrated in the STP structure diagram below¹:



¹ This diagram has been slightly updated since it was also included in the Leeds LDR.

- 3.20 Over 40 leads (at mainly Senior Manager and Director-level) from across the partnership have been assigned to one or more of the Elements / Enablers to work together to develop the detail. A flexible, responsive and iterative process to developing the STP has been deployed, focussing on the gaps, the solutions to address the gaps, and impact / dependencies across the other areas.
- 3.21 Workshops have taken place with Senior Managers / Directors from across all partners and the 3rd sector to understand what key solutions and plans are being developed across the Elements and Enablers, to develop a 'golden thread' or narrative that describes all of the proposed changes in terms of a whole system, and to provide constructive input into the solutions.

Local Digital Roadmaps

- 3.22 Alongside the development of the STP, there has also been a national requirement to develop and submit a Local Digital Roadmap (LDR). The LDR is a key priority within the NHS Five Year Forward View and an initial submission was made to NHSE at the end of June, after working with the Leeds Informatics Board and other stakeholders. The LDR describes a 5-year digital vision, a 3-year journey towards becoming paper-free-at-the-point-of-care and 2-year plans for progressing a number of predefined 'universal capabilities'. Within this, it demonstrates how digital technology will underpin the ambitions and plans for service transformation and sustainability.
- 3.23 LDRs are required to identify how local health and care systems will deploy and optimise digitally enabled capabilities to improve and transform practice, workflows and pathways across the local health and care system. Critically, they will be a gateway to funding for the city but they are not intended to be a replacement for individual organisations' information strategies. Over the next 5 years, funding of £1.3bn is to be distributed across local health and social care systems to achieve the paper-free ambition.
- 3.24 The priority informatics opportunities identified in the LDR are:
- To use technology to support people to maintain their own health and wellbeing;
 - To ensure a robust IT infrastructure provision that supports responsive and resilient 24/7 working across all health and care partners;
 - To provide workflow and decision support technology across General Practice, Neighbourhood Teams, Hospitals and Social Care;
 - To ensure a change management approach that embeds the use of any new technology into everyday working practices.
- 3.25 It is recognised that resources, both financial and people (capacity and capability), are essential to delivering this roadmap. A city-first approach is critical and seeks to eradicate the multiple and diverse initiatives which come from different parts of the health and care system, which use up resources in an unplanned way and often confuse. The LDR will also ensure that digital programmes and projects are

aligned fully to agreed whole-system outcomes described in the health and wellbeing strategy and the STP.

- 3.26 A paper covering the LDR in greater detail is also being discussed at the September 6th Health and Wellbeing Board.

Key aspects of the emerging Leeds STP

- 3.27 The Leeds Health and Wellbeing Board has provided a strong steer to the shaping of the Leeds STP through discussions at formal Health and Wellbeing Boards on January 12th and April 21^s and two STP related workshops held on June 21st and July 28th. The Board has reinforced the commitment to the Leeds footprint. The Board also supports taking our ‘asset-based’ approach to the next level. This is enshrined in a set of values and principles and a way of thinking about our city, which identifies and makes visible the health and care-enhancing assets in a community. It sees citizens and communities as the co-producers of health and well-being rather than the passive recipients of services. It promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment. It values what works well in an area and identifies what has the potential to improve health and well-being. It supports individuals’ health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. It empowers communities to control their futures and create tangible resources such as services, funds and buildings.
- 3.28 The members of the Board have also placed the challenge that as a system we need to think and act differently in order to meet the challenges and ensure that “Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest”.

Challenges faced by Leeds

- 3.29 The city faces many significant health and social care challenges commensurate with its size, diversity, urban density and history. We continue to face significant health inequalities between different groups. 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.
- 3.30 We have identified several specific areas where, if we focused our collective efforts, we predict will have the biggest impact in addressing the health and wellbeing gap, care quality gap and finance & efficiency gap.
- 3.31 The Health and Wellbeing Board has considered these gaps and what could be done to address them, as set out below.

Health and Wellbeing Gaps	Care and Quality Gaps
<p>Life expectancy for men and women remains significantly worse in Leeds than the national average. The gaps that we need to address are set out below:</p> <p>HW1 - Cardiovascular disease (CVD) mortality is significantly worse than for England</p> <p>HW2 - Cancer mortality is significantly worse than the rest of Yorkshire and the Humber</p> <p>HW3 - Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL</p> <p>HW4 - PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived</p> <p>HW6 - Suicides have increased</p>	<p>The following NHS Constitutional KPIs have been identified as the areas to focus on to reduce the care and quality gap:</p> <p>CQ1 - Mental Health (including IAPT)</p> <p>CQ2 - Patient Satisfaction</p> <p>CQ3 - Quality of Life</p> <p>CQ4 - A&E and Ambulance Response Times</p> <p>CQ5 - Delayed Transfers of Care (DTCO)</p> <p>CQ6 - Hospital admission rates</p> <p>CQ7 – The capacity gap created by difficulties in recruiting and retaining staff, coupled with a rising demand</p> <p>CQ8 - Difficulties in providing greater access to services in and out of hours</p>
Finance and Efficiency Gaps	
<p>The financial gap facing the city (if we were to do nothing about it) would be £723m over the next five years.</p> <p>This estimate reflects the forecast level of pressures facing the four statutory delivery organisations in the city and assumes that our three Leeds CCGs continue to support financial pressures in other parts of their portfolio whilst meeting NHS business rules.</p>	

Health and wellbeing gap

- 3.32 It is recognised that, despite best efforts, health improvement is not progressing fast enough and health inequalities are not currently narrowing. Life expectancy for men and women remains significantly worse in Leeds than the national average. The gap between Leeds and England has narrowed for men, whilst the gap between Leeds and England has worsened for women. Cardiovascular disease mortality is significantly worse than for England. However, the gap has narrowed. Cancer mortality is significantly worse than the rest of Yorkshire and the Humber (YH) and England with no narrowing of the gap. There is a statistically significant difference for women whose mortality rates are higher in Leeds than the YH average. The all-ages-all-cancers trend for 1995-2013 is improving but appears to be falling more slowly than both the YH rate and the England rate, which is of concern.
- 3.33 Avoidable Potential Years of Life Lost (PYLL) from Cancer for those under 75 years of age is a new measure which takes into account the age of death as well as the cause of death. Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL. PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived. Infant mortality has significantly reduced from being higher than the England rate to now being below it. Suicides have increased, after a decline, and

are now above the England rate. Within Leeds, for the big killers there has been a significant narrowing in the gap for deprived communities for cardiovascular disease, a narrowing of the gap for respiratory disease but no change for cancer mortality. There are 2,200 deaths per year <75 years. Of these 1,520 are avoidable (preventable and amendable) and, of these, 1,100 are in non-deprived parts of Leeds and 420 in deprived parts of Leeds.

3.34 The following are opportunities where action to address the gap might be identified:

- Scaling up – Scaling up of targeted prevention to those at high risk of Cardiovascular disease, diabetes, smoking related respiratory disease and falls. In addition, scaling up of children and young people initiatives already in existence, such as Best Start and childhood obesity / healthy weight programmes.
- Look at options to move to a community-based approach to health beyond personal / self-care. Scale up the Leeds Integrated Healthy Living Service; aligning partner Commissioning and provision, inspiring communities and partners to work differently – including physical activity/active travel, digital, business sector, developing capacity and capability.
- Increased focus on prevention - for short term and longer term benefits.

Care and quality gap

3.35 The following gaps have been identified:

- There are a number of aspects to the Care and Quality gap. In terms of our NHS Constitutional Key Performance Indicators (KPIs) the areas where significant gaps have been identified include: Mental Health (including Improving Access to Psychological Therapies), Patient Satisfaction, Quality of Life, Urgent Care Standards, Ambulance Response Times and Delayed Transfers of Care (DTC).
- Whilst performance on the Urgent Care Standard is below the required level, performance in Leeds is better than most parts of the country. There is a need to ensure that a greater level of regional data is used to reflect the places where Leeds residents receive care.
- There are 4 significant challenges facing General Practice across the city: the need to align and integrate working practices with our 13 Neighbourhood Teams; the need to provide patients with greater access to their services (this applies to both extended hours during the 'working week', and also at weekends); the severe difficulties they are experiencing in recruiting and retaining GPs and practice nurses; and the significant quality differential between the best and worst primary care estate across the city.
- There is a need to ensure that there is a wider context of Primary Care, outside of general practices that must be considered.

3.36 The following are opportunities where action to address the gap might be identified:

- More self-management of health and wellbeing.
- Development of a workforce strategy for the city which considers: increasing the ‘transferability’ of staff between the partner organisations; widespread up-skilling of staff to embed an asset-based approach to the relationship between professionals and service users; attracting, recruiting and retaining staff to address key shortages (nurses and GPs); improved integration and multi-skilling of the unregistered workforce and opportunities around apprenticeships; workforce planning and expanding the content and use of the citywide Health and Care workforce database.
- Partnerships with university and business sectors to create an environment for solutions to be created and implemented through collaboration across education, innovation and research.
- Maternity services - Key areas requiring development include the increased personalisation of the maternity offer, better continuity of care, increased integration of maternity care with other services within communities, and the further development of choice.
- Children’s services - In a similar way, for children’s services the key area requiring development is that of emotional and mental health support to children and younger people. Key components being the creation of a single point of access; a community based eating disorder service; and primary prevention in children’s centres and schools both through the curriculum and anti-stigma campaigns.

Finance and efficiency gap

3.37 The following gaps have been identified:

- The projected collective financial gap facing the Leeds health and care system (if we did nothing about it) is £723 million by 2021. It reflects the forecast level of pressures facing the four statutory delivery organisations (Leeds City Council, Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust) in the city and assumes that our three CCGs continue to support financial pressures in other parts of their portfolio whilst meeting NHS business rules. This is driven by inflation, volume demand, lost funding and other local cost pressures.

3.38 The following opportunities were discussed as some of the areas where action to address the gap might be identified:

- Citywide savings will need to be delivered through more effective collaboration on infrastructure and support services. To explore opportunities to turn the ‘demand curve’ on clinical and care pathways through: investment in prevention activities; focusing on the activities that provide the biggest return and in the parts of the city that will have the greatest impact;

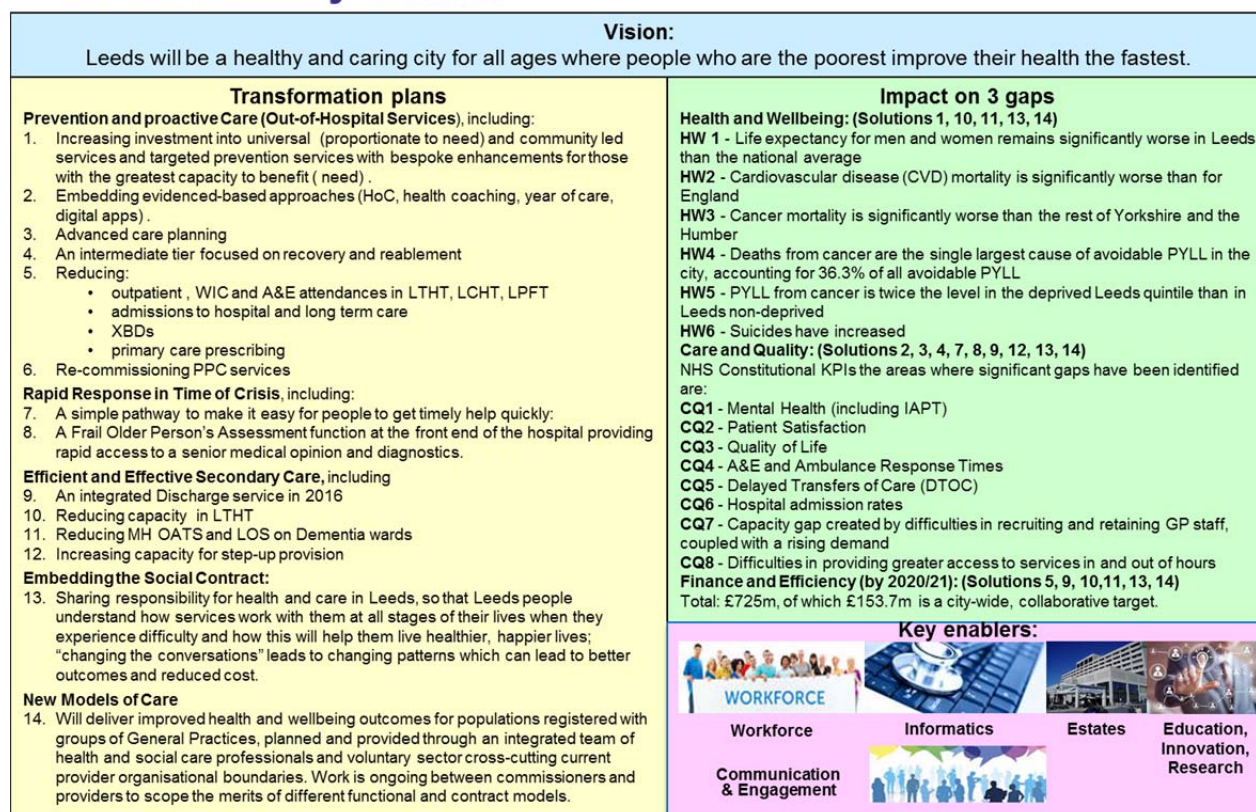
maximising the use of community assets; removing duplication and waste in cross-organisation pathways; ensuring that the skill-mix of staff appropriately and efficiently matches need across the whole health and care workforce e.g. nursing across secondary care and social care as well as primary care; and by identifying services which provide fewer outcomes for local people and offer less value to the 'Leeds £'.

- Capitalise on the regional role of our hospitals using capacity released by delivering our solutions to support the sustainability of services of other hospitals in West Yorkshire and build on being the centre for specialist care for the region.

Emerging Leeds STP – linking solutions to the gaps

3.39 The following diagram illustrates how the emerging themes and solutions in the Leeds STP support the identified gaps²:

Local delivery: *Leeds*



1

² This diagram has been slightly updated since it was also included in the Leeds LDR.

Emerging Leeds STP – supporting the Leeds Health and Wellbeing Strategy

3.40 The Leeds STP will have specific themes which will look at what action the health and care system needs to take to help fulfil the priorities identified within the Leeds Health and Wellbeing Strategy. Currently these emerging themes include:

- **Rebalancing the conversation with staff, service users and the public** - which supports the ethos of the refreshed Leeds Health and Wellbeing Strategy and sees citizens and communities as the co-producers of health and wellbeing rather than the passive recipients of services. It also emphasises individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources. This will also support Leeds Health and Wellbeing Strategy Priority 3 – 'Strong, engaged and well connected communities' and Priority 9 'Support self-care, with more people managing their own conditions' - using and building on the assets in communities. 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.
- **Prevention, Proactive Care and Rapid Response to in time of crisis** – which directly relates to the Priority 8 - 'A stronger focus on prevention' - the role that people play in delivering the necessary focus on prevention and what action the system needs to take to improve prevention, and Leeds Health and Wellbeing Strategy Priority 12 'The best care, in the right place, at the right time'. 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 co-ordination 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.
- **Efficient and Effective Secondary Care** – which also contributes to Leeds Health and Wellbeing Strategy Priority 12 'The best care, in the right place, at the right time'. This is ensuring that we have streamlined processes and only admitting those people who need to be admitted. As described above 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 and care provided in and out of hospital. Where a citizen has to use secondary care we will be putting ourselves in the shoes of the citizen and asking if the STP answers, 'Can I get effective testing and treatment as efficiently as possible?'
- **Innovation, Education, Research** - which relates to Leeds Health and Wellbeing Strategy Priority 7 – 'Maximise the benefits from information and

technology’ – how technology can give people more control of their health and care and enable more coordinated working between organisations. 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. Leeds Health and Wellbeing Strategy Priority 11 – ‘A valued, well-trained and supported workforce’, and priority 5 – ‘A strong economy with quality local jobs’ – through things such as the development of a the Leeds Academic Health Partnership and the Leeds Health and Care Skills Academy and better workforce planning ensuring the workforce is the right size and has the right knowledge and skills needed to meet the future demographic challenges.

- Mental health and physical health will be considered in all aspects of the STP within the Leeds STP but also there will be specific focus on Mental Health within the West Yorkshire STP, directly relating to Leeds Health and Wellbeing Strategy Priority 10 – ‘Promote mental and physical health equally’.

3.41 When developing the STP, we will keep the citizen at the forefront and asking the following questions identified in the Leeds Health and Wellbeing Strategy:

- *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?*

4 Wider considerations

4.1 Consultation and Engagement

4.1.1 The purpose of this report is to share information about the progress of development of the Leeds STP. A primary guiding source for the Leeds STP has been the refreshed Leeds Health and Wellbeing Strategy which has been widely engaged on through its development.

4.1.2 The final draft of the STP will be presented to statutory health and care partner governing boards in the autumn.

4.1.3 As part of the final STP, there will be a clear roadmap for delivery of the service changes over the next 4-5 years. This will also identify how and when engagement, consultation and co-production activities will take place with staff, service users and the wider public around.

4.1.4 In relation to the West Yorkshire STP, this engagement is being planned and managed through the West Yorkshire Healthy Futures Programme Management Office and is currently being finalised.

4.2 Equality and diversity / cohesion and integration

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

4.3 **Resources and value for money**

- 4.3.1 The final Leeds STP will have to describe the financial and sustainability gap in Leeds, the plan Leeds will be undertaking to address this and demonstrate that the proposed changes will ensure that we are operating within our likely resources. In order to make these changes, we will require national support in terms of local flexibility around the setting of targets, financial flows and non-recurrent investment.
- 4.3.2 As part of the development of the West Yorkshire STP, the financial and sustainability impact of any changes at a West Yorkshire level and the impact on Leeds will need to be carefully considered and analysis is currently underway to delineate this.
- 4.3.3 It is envisaged that Leeds may be able to capitalise on the regional role of our hospitals using capacity released by delivering our solutions to support the sustainability of services of other hospitals in West Yorkshire and to grow our offer for specialist care for the region.

4.4 **Risk management**

- 4.4.1 Failure to have robust plans in place to address the gaps identified as part of the STP development will impact the sustainability of the health and care in the city.
- 4.4.2 Two key overarching risks present themselves, given the scale and proximity of the challenge and the size and complexity of both the West Yorkshire footprint and Leeds itself:
- Potential unintended and negative consequences of any proposals as a result of the complex nature of the local and regional health and social care systems and their interdependencies. Each of the partners has their own internal pressures and governance processes they need to follow.
 - Ability to release expenditure from existing commitments without destabilising the system in the short-term will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.
- 4.4.3 The challenge also remains to develop a cohesive narrative between technology plans and how they support the STP plans for the city. Leeds already has a defined blueprint for informatics, strong cross organisational leadership and capability working together with the leads of each STP area to ensure a quality LDR is developed and implemented.
- 4.4.4 Whilst the in Leeds the health and care partnership has undertaken a review of non-statutory governance to ensure it is efficient and effective, the bigger West Yorkshire footprint upon which we have been asked to develop an STP will present much more of a challenge.
- 4.4.5 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the

developing a robust STP and then delivering the STP within an effective governance framework.

5 Conclusions

5.1 As statutory organisations across the city working with our thriving volunteer and third sectors and academic partners, we have come together to develop, for the first time, a system-wide plan for a sustainable, high-quality health and social care system. We want to ensure that services in Leeds can continue to provide high-quality support that meets, or exceeds, the expectations of adults, children and young people across the city: the patients and carers of today and tomorrow.

5.2 Our Leeds STP will be built on taking our asset-based approach to the next level to help deliver the health and care aspects of the Leeds Health and Wellbeing Strategy. This is enshrined in a set of values and principles and a way of thinking about our city, which:

- Identifies and makes visible the health and care-enhancing assets in a community;
- Sees citizens and communities as the co-producers of health and well-being rather than the passive recipients of services;
- Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment;
- Values what works well in an area;
- Identifies what has the potential to improve health and well-being the fastest;
- Supports individuals' health and well-being through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources;
- Empowers communities to control their futures and create tangible resources such as services, funds and buildings;
- Values and empowers the workforce and involves them in the coproduction of any changes.

5.3 The following table summarises, at a high-level, the key changes that we expect to take place over the next five-plus years and which will provide the greatest leverage.

Key solutions to address gaps and create sustainable health & care for the future		
'Changing the conversation' and working with the public, service users and our workforce.	Investing more in prevention, targeting those areas that will reap the greatest impact.	
Increasing and integrating our community offer for out-of-hospital health and social care, providing proactive care and rapid response in a time of crisis.	Capitalising on the regional role of our hospitals, using capacity released by delivering our solutions to support the sustainability of services of other hospitals in West Yorkshire.	
Supported by...		
Working with people at every stage of change through clear comms & engagement.	Having a national pioneering integrated digital infrastructure being used by a 'digitally literate' workforce.	Creating an encouraging and supportive environment for solutions to be produced and for economic investment through collaboration & partnerships
Using existing estate more effectively, ensuring that it is fit for the purpose, and disposing of surplus estate.	Reviewing our procurement practices and top 100 supplier organisation spend to ensure that we are getting best value in spending for our 'Leeds £' and are benefitting from economies of scale	Creating 'one' workforce supported by leading and innovative workforce education, training and technology

5.4 Our strategy is based on the following imperatives:

- the four statutory delivery organisations will be efficient and effective within their own 'boundaries' by reducing waste and duplication generally
- all partners will collaborate more effectively on infrastructure and support services
- we will turn the 'demand curve' through:
 - investment in prevention activities, focusing on those that provide the biggest return and in the parts of the city that will have greatest impact
 - re-balancing the social contract between our citizens and the statutory bodies, transferring some activities currently undertaken by employees in the statutory sector to individuals, and maximising the use of community assets
 - reducing waste and duplication in cross-organisational pathways;
 - ensuring that the skill-mix of staff appropriately and efficiently matches need - movement from specialist to generalist, from qualified professional to assistant practitioner, and from assistant practitioner to care support worker

5.5 There is significant work still to do to develop the Leeds STP to the required level of detail. Colleagues from across the health and social care system will need to commit substantial resource to producing the final draft. Additionally, senior

leaders from Leeds will continue to take a prominent role in shaping the West Yorkshire STP.

5.6 It is important to recognise that the West Yorkshire STP is still in its development and the links between this and the six local STPs are still being developed. Getting the right read-across between plans to ensure a coherent and robust STP at regional level which meets the requirements of national transformation funding needs to be an ongoing process and Leeds will need to be mindful of this whilst developing local action.

5.7 Over the coming months, Leeds will continue to prioritise local ambitions and outcomes through the development of its primary STP as a vehicle for delivering aspects of the Leeds Health and Wellbeing Strategy.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Consider – does it endorse the approach described within this paper for the continued development of the Leeds and West Yorkshire STPs, within the nationally prescribed framework?;
- Note the key areas of focus for the Leeds STP described in this report and how they will contribute to the delivery of the Leeds Health and Wellbeing Strategy;
- Note that the Leeds Health and Wellbeing Board will continue to provide a strategic lead for the Leeds STP;
- Note the key milestones outlined in this paper and the officers from the Leeds health and care partnership who are leading the development of the Leeds STP and the West Yorkshire STP;
- Receive a further report at a future meeting of the Health and Wellbeing Board, with an overview of the proposed key changes and impacts outlined in the Leeds STP and the West Yorkshire STP, as we move forward towards implementation and oversight.

7 Background documents³

7.1 N/A

³ The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

APPENDIX: THE WEST YORKSHIRE STP – UPDATE

Update for Boards August 2016

Health and care partner organisations across the NHS and Local Government in West Yorkshire have been planning together to develop the five year West Yorkshire STP (WYSTP) for four months now. The WYSTP is formed from the six local place-based plans and a set of supporting West Yorkshire programmes.

As the WYSTP (both the local plans and the WY level programmes) develop, updated versions have to be submitted to a group of national bodies including NHS England, NHS Improvement and the Local Government Association. There have been two such checkpoint submissions so far, the most recent was on 30 June 2016.

We will work towards agreeing a final WYSTP during July & August, seeking approval from all our Health & Well Being Boards, CCG Governing Bodies and provider Trust Boards in September/October 2016, once the submission process and timescales are finalised by NHS England. Local Authority partners have also agreed to have a one-off meeting of all Health and Wellbeing Board Chairs and Council Leaders to discuss any collective view on this before final submission.

This is a five year plan and the focus is on providers and commissioners collectively returning a currently unsustainable health and care system to long-term sustainability by 2020/21. Our planning for the WYSTP is therefore emerging as we understand better how we collectively deliver sustainability, and our submissions to date represent checkpoints on how our plan is evolving.

Improving Outcomes

The focus of all planning across the WYSTP is firmly based around improving benefits to and outcomes for our population based on our understanding of:

1. their needs through local and West Yorkshire joint needs assessment and the wider determinants of health, and
2. where there are gaps (variations) in outcomes in peoples' health & well-being, the quality and care they receive as patients and service users, and the funding available to deliver that care.

Planning across all services and all 'places' in the West Yorkshire footprint is complex and will take time to get right so that we target interventions and programmes of transformation where they are needed most (improving outcomes) and have the greatest impact on closing gaps and reducing variation.

Principles

There is clear recognition of the principle of subsidiarity and that planning and transformation should take place at the most appropriate level. The vast majority of transformation to improve outcomes is being delivered at a local level with our populations, communities and the services supporting them, with self-care and providing care wrapped around their homes. This is defined in each of the six local place-based plans, tailored to meet the needs of their local populations.

We are also working to establish a shared and honest analysis of the problems, issues and challenges we face in West Yorkshire and how we do our work once as a system, in order to minimise conflict and the resources we use.

Governance & Engagement

Our success will depend on *collectively understanding* the WY system and *making decisions jointly* as a system and *at all levels* – local CCGs and Health and Well-Being Boards, across provider Boards, across Local Authorities, and as a West Yorkshire Leadership Team (which has representation from all partner organisations).

A significant amount of effort, for example, has been spent on establishing the relationships and governance required by all health partner organisations to augment their current statutory authority and allow them to come together collectively to make recommendations and decisions. This has included developing new ways of working with regulatory bodies and exploring how the system can assure itself collectively that it is working towards reducing the current gaps, and manages risks to sustainability.

The Leadership Team are supported by the Clinical Forum and are now coming together for Leadership Days every month to progress planning and discuss the challenges and possible solutions as a system.

We continue to engage daily with our partners and engagement around the emerging WYSTP will start with our local communities and workforce as priorities and plans are agreed collectively by our Boards.

Our work to date

Year one (2016/17) and planning to date as a system has been about jointly understanding gaps and variations in outcomes, the pressures on services which are making them unsustainable and the contribution that collaborative programmes and local place-based plans can make to close these gaps and improve outcomes. This will provide an agreed foundation from which we can effectively plan and prioritise the transformation required over five years to address these gaps.

There are currently a number of priority West Yorkshire workstreams planning and delivering collaborative programmes of work at a West Yorkshire level. These augment transformation being delivered through local place-based plans, and provide an opportunity to share best practice and deliver transformation at scale to improve outcomes for our population in a way we cannot do locally. These West Yorkshire workstreams include: prevention at scale, cancer, mental health, urgent and emergency care, specialised commissioned services, stroke, primary and community services (focused on sharing local innovation and best practice) and sustainable acute services (with a strong link to mental health, cancer, stroke, and urgent and emergency care).

Key Dates:

2 August 2016: Leadership Day: meeting of the Clinical Forum and Leadership Team

31 August 2016: informal submission of the finance template to regional NHS England Team

6 September: Leadership Day: meeting of the Clinical Forum and Leadership Team – approval key content of the WYSTP and draft communications and engagement strategy

16 September 2016: submission of final finance template / plan to national team within NHS England

September / October 2016: approvals process with all partner Boards across West Yorkshire

October 2016 (date TBC): submission of final West Yorkshire STP.

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Leeds Health & Wellbeing Board

Report author: Julie Oxley/Alastair Cartwright

Report of: Dr Jason Broch (Clinical Chair and GP, NHS Leeds North CCG)

Report to: The Leeds Health and Wellbeing Board

Date: 06 September 2016

Subject: Local Digital Roadmap (LDR)

Are there implications for equality and diversity and cohesion and integration?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Is the decision eligible for Call-In?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Appendix number:		

Summary of main issues

This report aims to describe the purpose of the Local Digital Roadmap and inform the Health and Wellbeing Board of how it contributes to the delivery of the digital infrastructure capability required to meet the needs of the health and care system in the future.

Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the Local Digital Roadmap as a key contributor to the delivery of both the Leeds Sustainability and Transformation Plan and Leeds Health and Wellbeing strategy.
- Consider their role in championing the adoption of technology and ensuring that the realisation of benefits is seen as a core part of all city-wide 'change' initiatives.

1 Purpose of this Report

1.1 This report aims to describe the purpose of the Local Digital Roadmap and inform the Health and Wellbeing Board of how it contributes to the delivery of the digital infrastructure capability required to meet the needs of the health and care system in the future.

2 Background information

- 2.1 The creation of Local Digital Roadmaps was first referenced within the Five Year Forward View (2014) in support of the vision to exploit the worldwide information revolution. The Forward View described a number of expectations for the future health and care service, including the use of health apps, shared electronic patient records and organisations becoming ‘paper-free’ at the point of care.
- 2.2 The Leeds Local Digital Roadmap is thus the local response to this requirement as it has emerged from NHS England. The aim has been to ensure that national requirements are matched with local requirements and therefore to the infrastructure capability required to meet the needs of the Leeds health and care system in the future.
- 2.3 The production of the Leeds Local Digital Roadmap has been a helpful and timely way of articulating further details behind the Health and Wellbeing strategy priority to ‘maximise the benefits from information and technology’. It addresses the Health and Wellbeing Board’s focus on:
- Reducing health inequalities in Leeds
 - Creating a high quality health and care system
 - Having a financially sustainable health and care system
- 2.4 The Leeds Local Digital Roadmap has used the same look and feel branding as the Health and Wellbeing strategy, thus illustrating the shared themes.
- 2.5 The Leeds Local Digital Roadmap outlines initiatives that will ensure that Leeds is a compassionate city; engaging with our citizens, recognising the role they can play in using technology to assist with their health and wellbeing, as well as specifics such as technology to support joint care and end-of-life plans.
- 2.6 The Leeds Local Digital Roadmap is expected to have an annual revision. The initial submission to NHS England on 30th June (see appendix 1) has 3 different aims:
- First, it describes a 5-year digital vision which has accounted for the Leeds Sustainability and Transformation Plan and the Leeds Health and Wellbeing strategy.
 - Second, it describes a 3-year journey towards becoming paper-free-at-the-point-of-care, a significant focus of national information strategy and the National Information Board (NIB).
 - Third, it forms a 2-year plan to progress a number of predefined ‘universal’ NHS England required digital capabilities. In many cases these are national technology investments that have yet to be fully embraced across health and care nationally.
- 2.7 In turn, and again in line with the NHS Forward View, the nationally required Sustainability and Transformation Plans (STP) are “expected to have a ‘golden thread’ of digital technology running through their ambitions and plans.
- 2.8 The LDR identifies how local health and care systems will deploy and optimise digitally-enabled capabilities to improve and transform practice, workflows and

pathways across the local health and care system

- 2.9 The LDR is system-wide, covering commissioners and providers of primary care, secondary care (acute, community, mental health and ambulance) and social care (local authorities and social care providers). However, they are not intended to be a replacement for individual organisational informatics strategies.
- 2.10 The LDR is a 'gateway' to national funding.
- 2.11 Prior to the LDR submission each provider organisation was asked to complete a digital maturity assessment which set out each organisations current state in terms of sharing information electronically. This was then used to form the basis for the 'roadmap' towards paper-free-at-the-point-of-care.
- 2.12 The LDR has been developed to ensure that there are clear links with key stakeholders and involvement by all health and care partners in Leeds, including:
- NHS Leeds North Clinical Commissioning Group
 - NHS Leeds West Clinical Commissioning Group
 - NHS Leeds South and East Clinical Commissioning Group
 - Leeds City Council
 - Leeds Teaching Hospitals NHS Trust
 - Leeds Partnership NHS Foundation Trust
 - Leeds Community Healthcare NHS Trust
 - General Practice
 - Informatics leads from West Yorkshire Clinical Commissioning Groups
 - West Yorkshire Urgent and Emergency Care Network/Vanguard
 - Leeds Third Sector organisations
- 2.13 It should be noted that the STP diagrams on pages 6 and 7 of the Local Digital Roadmap (appendix 1) have been updated as part of the ongoing STP development process.

3 Main issues

- 3.1 The expectation is that national funding will be made available to support key priorities within the LDR. Over the next five years NHS England have committed that funding of £1.3bn is to be distributed across local health and care systems to achieve the specific ambition of paper-free at the point of care. Paper-free at the point of care remains a prime focus if the first submission of the Local Digital Roadmap.
- 3.2 The expectation is that Local Digital Roadmaps will be delivered via multiple funding sources. For Leeds these will include NHS England funding allocated to delivery National Information Board priorities, Better Care Fund, existing organisational capital and revenue technology and information budgets and investment from the private sector.

- 3.3 Amongst the list of digital requirements described within the LDR, there are 4 specific priority areas highlighted for Leeds. These are:
- Using technology to maximise the contribution that citizens can make to maintain their own health and wellbeing
 - Provision of a robust IT infrastructure that supports 24/7 working across all health and care partners
 - Provision of workflow and decision support technology across General Practice, Neighbourhood Teams, Hospitals and Social Care
 - Adoption of a change management approach that embeds the use of any new technology into everyday working practices

3.4 The LDR has addressed how 'digital' will assist with the 3 priority gaps within the STP, and supporting the Health and Wellbeing strategy, these being:

3.4.1 The health inequality gap

An example of our digital response includes:

'To improve digital literacy skills for citizens to ensure that they are not excluded from technology enabled healthcare solutions and technology enabled self-care opportunities'

3.4.2 The care and quality gap

An example of our digital response includes:

'Provide facilities to enable health and care professionals to navigate pathways across sectors'

3.4.3 The finance and efficiency gap

An example of the digital response includes:

'Continue to design and deliver city- or place-based solutions, exploiting the combined capabilities and resources across health, care, local government and academia';

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Engagement with citizens and professionals forms a key part of the LDR. This will either be through the STP or in its own right. For example we will build upon the strong and mature engagement work already commenced as part of the Leeds Care Record initiative and the 'Joined Up Leeds' citizen engagement.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Each programme/project within the LDR will make assessment of the impact in relation to equality and diversity/cohesion of their delivery.

4.3 Resources and value for money

4.3.1 Leeds has submitted the LDR and is awaiting a national investment decision to enable a programme of work to commence in 2017/18. Plans are being made to identify the delivery programmes and resource requirements to achieve what has been set out in the LDR. Full delivery will be via multiple funding sources.

4.4. **Legal Implications, Access to Information and Call In**

4.4.1 The LDR is a national requirement from NHS England and is subject to national assessment to access informatics funding.

4.5 **Risk Management**

4.5.1 The LDR identifies a number of risks to delivery.

5 **Conclusions**

5.1 This is the first iteration of the Leeds Local Digital Roadmap. The aim was to reflect a 5-year vision and strategy, aligned to the STP and Health and Wellbeing strategy, and a 3-year journey towards 'paper free' at the point of care and a series of shorter-term deliverables.

5.2 There is a golden thread between the LDR and the STP gathered through close working with STP stakeholders. In turn, this reflects the Health and Wellbeing strategy.

5.3 The LDR is an iterative process and will continue to mature and ensure that it delivers the digital capability required in support of the Leeds Health and Wellbeing strategy.

5.4 The LDR is expected to be delivered via multiple funding streams.

6 **Recommendations**

6.1 The Health and Wellbeing Board is asked to:

- Endorse the Local Digital Roadmap as a key contributor to the delivery of both the Leeds Sustainability and Transformation Plan and Leeds Health and Wellbeing strategy.
- Consider their role in championing the adoption of technology and ensuring that the realisation of benefits is seen as a core part of all city-wide 'change' initiatives.

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Leeds - Local Digital Roadmap

First Submission - 30 June 2016

Introduction

Leeds aspires to be the best city to grow up in, the best city to grow old in, the best city for health and wellbeing and has the overall ambition to improve the health of the poorest fastest.

Leeds is making strong progress towards becoming a 'smart' city where voluntary, public and private sectors cooperate to achieve sustainable city outcomes and increase economic competitiveness. This includes the ability to share and exchange information across a whole city system.

Informatics, and the digital technology it oversees, is seen as central to the delivery of this ambition.

Leeds is the agreed footprint for the Local Digital Roadmap (LDR), covering the three Leeds NHS Clinical Commissioning Groups and the local health and care providers, including all GP Practices.

The Leeds Informatics unique selling points are:

- Our strong and long standing collaborative working arrangements around Informatics across health, care and academia
- Our robust information sharing arrangements between organisations
- Our engagement with citizens about how their information is and might be used to improve their health and care
- Our Leeds Care Record, an integrated view of health and care information with over 2000 active users
- Our use of joined up information and analytics across the city to provide knowledge and insights into how effective our health and care processes are

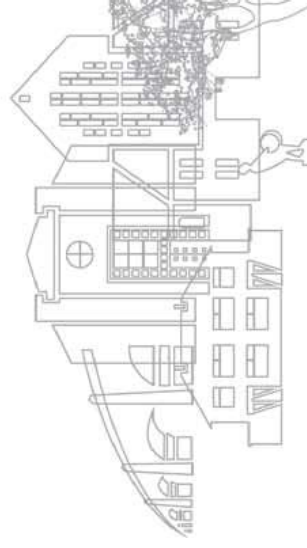
The priority Informatics opportunities described within the LDR are:

- To use technology to support people to maintain their own health and wellbeing
- To ensure a robust IT infrastructure provision that supports responsive and resilient 24/7 working across all health and care partners
- To provide workflow and decision support technology across General Practice, Neighbourhood Teams, Hospitals and Social Care
- To ensure a change management approach that embeds the use of any new technology into everyday working practices

The LDR has been produced in conjunction with the Leeds and West Yorkshire Sustainability and Transformation Plans (STP) and in collaboration with other LDRs across West Yorkshire.

The LDR is not intended to be a replacement for individual organisational informatics strategies but provides a consolidated view of the plans required to become as close as possible to 'paper free at the point of care' and to support the delivery of integrated health and care services.

The Leeds Local Digital Roadmap thus describes a 5-year digital vision, a 3-year journey towards becoming paper-free-at-the-point-of-care and 2-year plans for progressing a number of predefined 'universal capabilities'.



Endorsement and contributors

It was agreed at an early point that the Leeds STP would be the driving initiative, being communicated widely to all stakeholders, including to the Leeds Partnership Executive Group and the Leeds Health and Wellbeing Board. The LDR development has also had wide visibility either as a complementary aspect of the STP or in its own right. The agreed sign-off process for the LDR is via the Leeds Informatics Board to the Leeds Partnership Executive Group, with visibility provided to the Health and Wellbeing Board.

The main contributing organisations have been as follows:

- NHS Leeds North Clinical Commissioning Group (lead CCG)
- NHS Leeds West Clinical Commissioning Group
- NHS Leeds South and East Clinical Commissioning Group
- Leeds City Council
 - Adult Social Care
 - Children's Services
 - Public Health
- Leeds Teaching Hospitals NHS Trust
- Leeds Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- General Practice
- Informatics leads from West Yorkshire Clinical Commissioning Groups
- West Yorkshire Urgent and Emergency Care Network/Vanguard
- Leeds Third Sector organisations

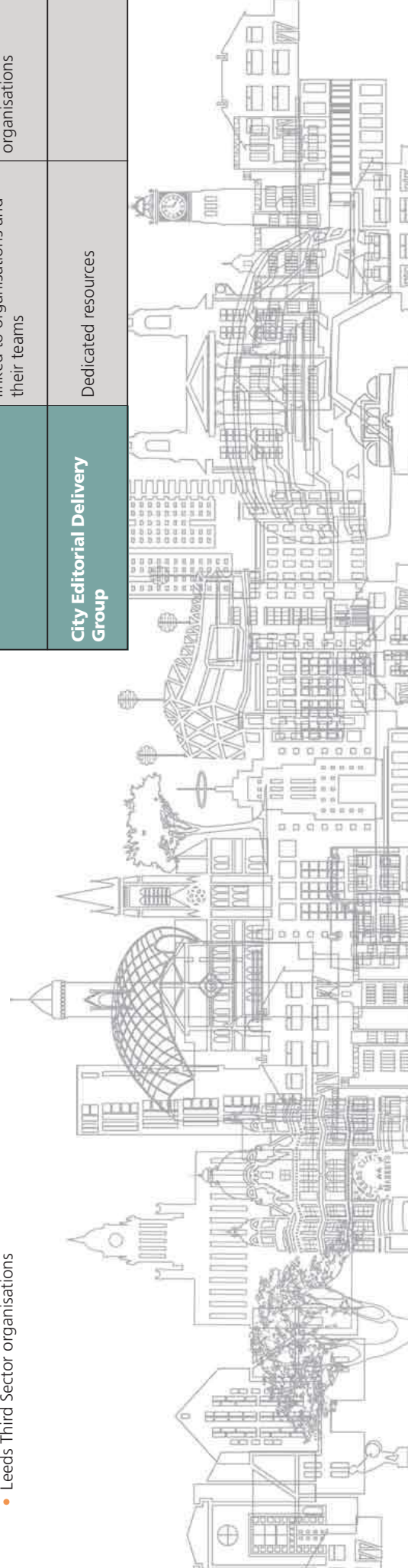
The LDR has been developed using the following approach:

Resources, roles and responsibilities to deliver the roadmap were identified and secured at an early stage. Stakeholders were identified. Communication and engagement of the LDR plans involved, briefings, meetings and bulletins which were managed alongside the STP communications plans. The range of activities undertaken has highlighted the excellent work already undertaken in Leeds along with capability gaps, delivery constraints and opportunities to share expertise, minimise duplication, standardise and integrate approaches where possible.

Involvement in the STP programme has been an integral part of the process.

The key stakeholder groups included:

Senior Stakeholders	Leeds Partnership Executive	Leeds Informatics Board
Stakeholders	STP delivery group	CCG Planners group
	City Chief Information Officers group	Specialists to contribute to technical and clinical aspects
	Chief Information Officers linked to organisations and their teams	Lead clinicians within organisations
City Editorial Delivery Group	Dedicated resources	

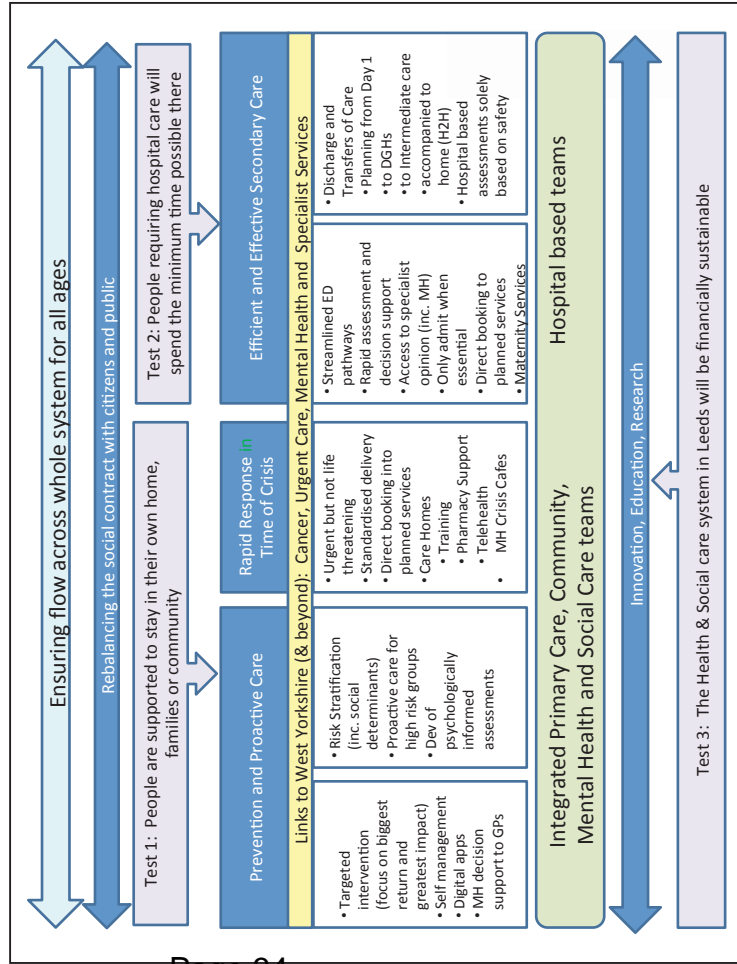


Sustainability and Transformation Plan

The delivery of digital solutions and the management of information in Leeds is an enabling component within the STP. The Local Digital Roadmap is as much about managing change and delivering new ways of working as it is about introducing new technologies.

The STP stakeholder workshops have included the digital leaders involved in the oversight of the LDR. Clinical leaders have worked with digital leaders to fully expose the transformational opportunities through the digital enablement of information pathways and self management and clinical support tools.

The following illustration describes the Leeds sustainability and transformation model where technology will support 'prevention and proactive care', 'rapid response in time of crisis' and 'efficient and effective secondary care':



Local delivery: Leeds

The STP has also described the required transformation plans, addressing the gaps and the enablers - one of which is Informatics:

<p>Vision: Leeds will be a healthy and caring city for all ages where people who are the poorest improve their health the fastest.</p>	<p>Transformation plans Prevention and proactive Care (Out-of-Hospital Services), including: 1. Increasing investment into universal (proportionate to need) and community led services and targeted prevention services with bespoke enhancements for those with greater capacity to benefit (these include: 2. Embedding evidenced-based approaches (i.e. health coaching, year of care, digital apps) 3. Advanced care planning 4. An intermediate tier focused on recovery and reablement 5. Reducing: • outpatient / WIC and A&E attendances in LHHT, LCHT, LPFT • admissions to hospital and long term care • XBDs • primary care prescribing 6. Re-commissioning PPC services Rapid Response in Time of Crisis, including: 7. A simple pathway to make it easy for people to get timely help quickly. 8. A Frail Older Person's Assessment function at the front end of the hospital providing rapid access to a senior medical opinion and diagnostics. Efficient and Effective Secondary Care, including 9. An integrated Discharge service in 2016 10. Reducing capacity in LHHT 11. Reducing MH OATs and LOS on Dementia wards 12. Increasing capacity for step-up provision Embedding the Social Contract: 13. Sharing responsibility for health and care in Leeds, so that Leeds people understand how services work with them at all stages of their lives when they experience difficulty and how this will help them live healthier, happier lives; "changing the conversations" leads to changing patterns which can lead to better outcomes and reduced cost.</p>
<p>Impact on 3 gaps Health and Wellbeing: (Solutions 1, 10, 11, 13, 14) HW1 - Life expectancy for men and women remains significantly worse in Leeds than the national average HW2 - Cardiovascular disease (CVD) mortality is significantly worse than for England HW3 - Cancer mortality is significantly worse than the rest of Yorkshire and the Humber HW4 - Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL HW5 - PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived HW6 - Suicides have increased Care and Quality: (Solutions 2, 3, 4, 7, 8, 9, 12, 13, 14) NHS Constitutional KPIs: the areas where significant gaps have been identified are: CO1 - Mental Health (including IAPT) CO2 - Patient Satisfaction CO3 - Quality of Life CO4 - Patient Experience CO5 - Delays in Response Times CO6 - Delays in Transfers of Care (DTCO) CO7 - Hospital admission rates CO8 - Capacity gap created by difficulties in recruiting and retaining GP staff, coupled with a rising demand CO9 - Difficulties in providing greater access to services in and out of hours Finance and Efficiency (by 2020/21): (Solutions 5, 9, 10, 11, 13, 14) Total: £725m, of which £153.7m is a city-wide, collaborative target.</p>	<p>Key enablers: Workforce Communication Informatics Estates Engagement Research</p>



Section 2

City Technology vision and strategy

Vision and strategy:

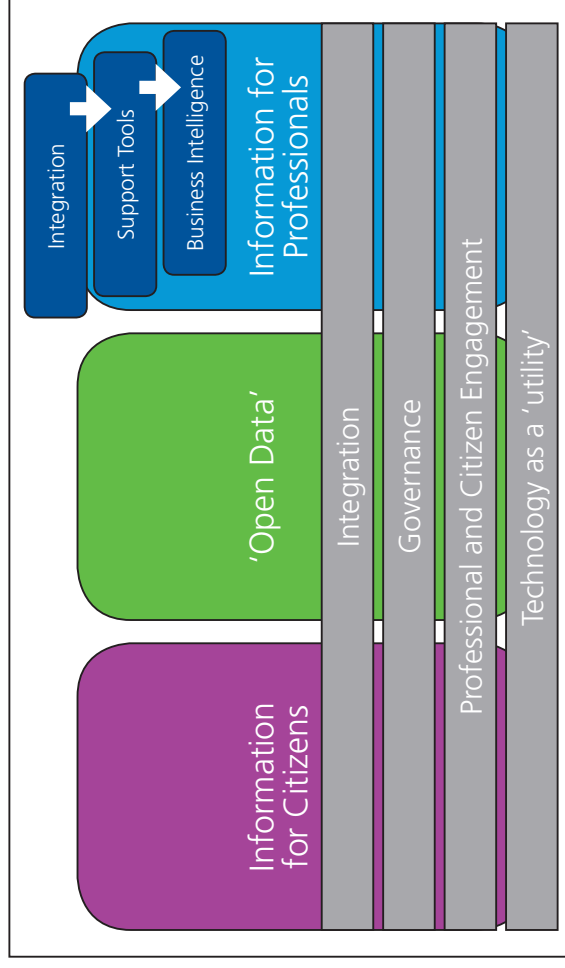
Leeds has designed a simple informatics 'blueprint' which describes our vision for the city.

There are three strategic building blocks that form our informatics vision to support improved health and wellbeing and improved health and care provision. These are:

- Information and technology that provides information for professionals;
- Information for citizens;
- 'Open data' that describes aspects of our city or our 'place', for example air quality and transport.

Informatics is thus the full range of technology and information management provision required to deliver this vision. This includes technology infrastructure such as data networks, information systems designed to collect and process information, the skills necessary to implement and operate systems and the use of the information produced.

Our simple Informatics strategy for the city



These three areas will be integrated with each other. Information from and for professionals will be available to our citizens. Information used by and collected by citizens will be available to professionals. 'Open data' will inform citizens about the communities that they live in. All of this is underpinned by a shared approach to how and what information is used, both in terms of governance and the conversations that take place between each other.

The 'smart city' programme for Leeds means that we take a 'digital first' approach to any new initiatives. All digital assets across the city will interoperate with each other and provide combined information from which we can gain new value and insight. We will build this incrementally by considering and incorporating "Digital by Design" in all new projects that we carry out across the city.

We will take a 'utility' based approach to providing the required technical infrastructure to achieve this vision. This means that we will reduce the unnecessary variation in areas such as mobile devices, wifi and desktops. This will also include how we deliver the technology professionals require, for example the ability to work anywhere, any time, any place across the city. It will also dictate the approach we take to

improve digital facilities for citizens, whether this will be public wifi, digital literacy or the way we work with industry to enable a marketplace for technology that supports citizen health and wellbeing.

Our approach is to simplify, standardise and share, and make available for national re-use where applicable.

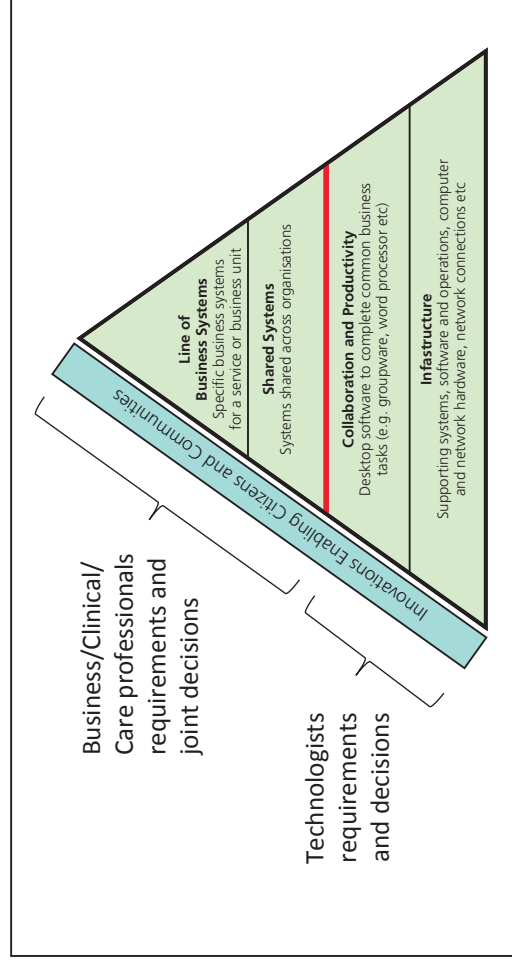
The city Chief Information Officers (CIOs) and Chief Clinical Information Officers (CCIOs) across Leeds have jointly proposed a city-first (or place-based) strategy and an integrated and open platform based approach to achieving our vision. This was signed up to by the citywide Partnership Executive Group in May 2016. All parties have signed up to a set of digital design principles.

Strategic approach to delivery and resources:

We have designed a strategic framework to delivery that distinguishes between our approach to delivering:

- 1 Technical infrastructure;
- 2 Systems that deliver directly to the business;
- 3 Innovations and research.

This is illustrated below:



We recognise that resources, both financial and people capacity and capability, are essential to delivering this roadmap. However, a city-first approach seeks to eradicate the multiple and diverse initiatives which come from different parts of the health and care system that use up resource in an unplanned way and often confuse. It will also ensure that digital programmes and projects are aligned fully to an agreed whole-system outcome described in the health and wellbeing strategy, STP and LDR.

Strategic approach to governance:

We have designed and agreed city-wide governance arrangements required to provide assurance on the delivery of digitally enabled health and wellbeing outcomes in Leeds, in line with the agreed design principles.

Accountability for delivery of the LDR and associated digital change programmes is delegated to the Leeds Informatics Board (LIB). This Board consists of a mix of senior leaders, clinicians and senior Informaticians. It is chaired by a senior clinician; a GP and Clinical Chair of Leeds North CCG.

Whilst individual organisations have information and technology strategies, at a city-level, a city-based function will be created to support the LIB, CIOs and CCIOs in the delivery of the Local Digital Roadmap. The function will provide support with planning, strategic compliance, business case development and delivery.

A key part of our strategy is that every digital or informatics enabled business/clinical change project should only be progressed if there is clear clinical/business sponsorship and resource to make the change happen. Capacity for clinicians and business managers to be involved in delivering change is a key strategic principle, supported by clinical leadership and clinical, business and digital champions.

We will also ensure that there is appropriate finance service support to work with CIOs and CCIOs to ensure that there is an equitable and sustainable approach to the funding of a city-wide approach to informatics as we deliver the transformation required as part of the digital roadmap.

Supporting the Sustainability and Transformation Plan:

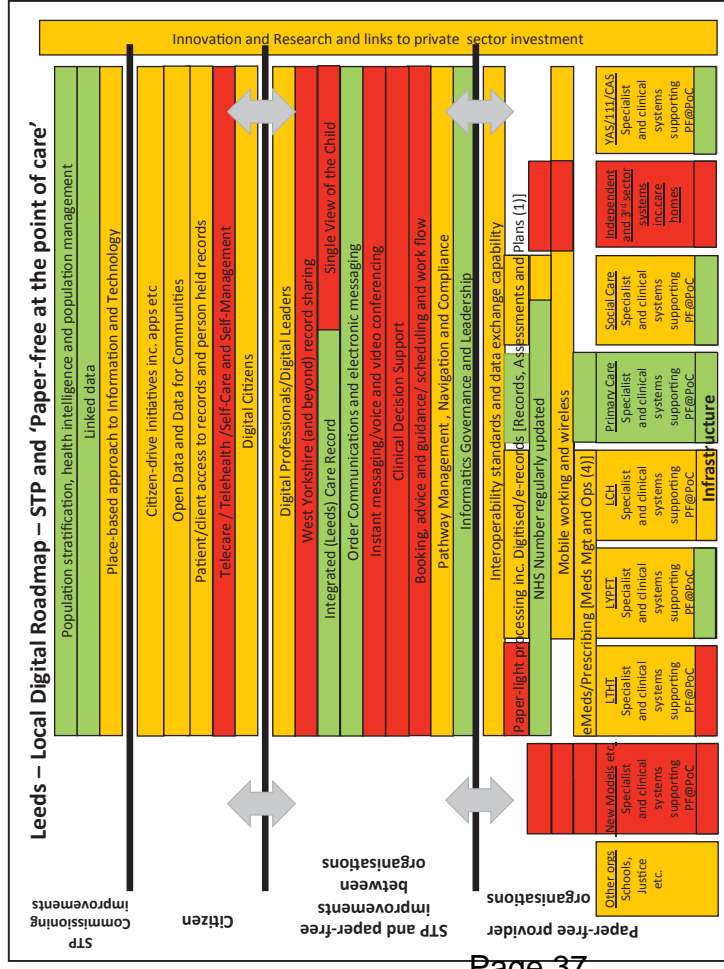
The Leeds STP recognises that city-wide savings will be delivered through more effective collaboration on infrastructure and support services and turning the 'demand curve' on clinical and care pathways. The work of the citywide informatics teams will make a key contribution to turning the demand curve. Our strategic priorities within the STP include:

- The use of technology to maximise the contribution that citizens can make to maintain their own health and wellbeing;
- The provision of a robust IT infrastructure that supports 24/7 working across all health and care partners;
- The provision of workflow and decision support technology across General Practice, Neighbourhood Teams, Hospitals and Social Care;
- The adoption of a change management approach that embeds the use of any new technology into everyday working practices.

Informatics has been part of a structured approach to developing the STP and has designed a number of outline capabilities that contribute to addressing:

- The health inequalities gap;
 - The care and quality gap;
 - The finance gap.
- We have identified a number of features that need to be delivered.

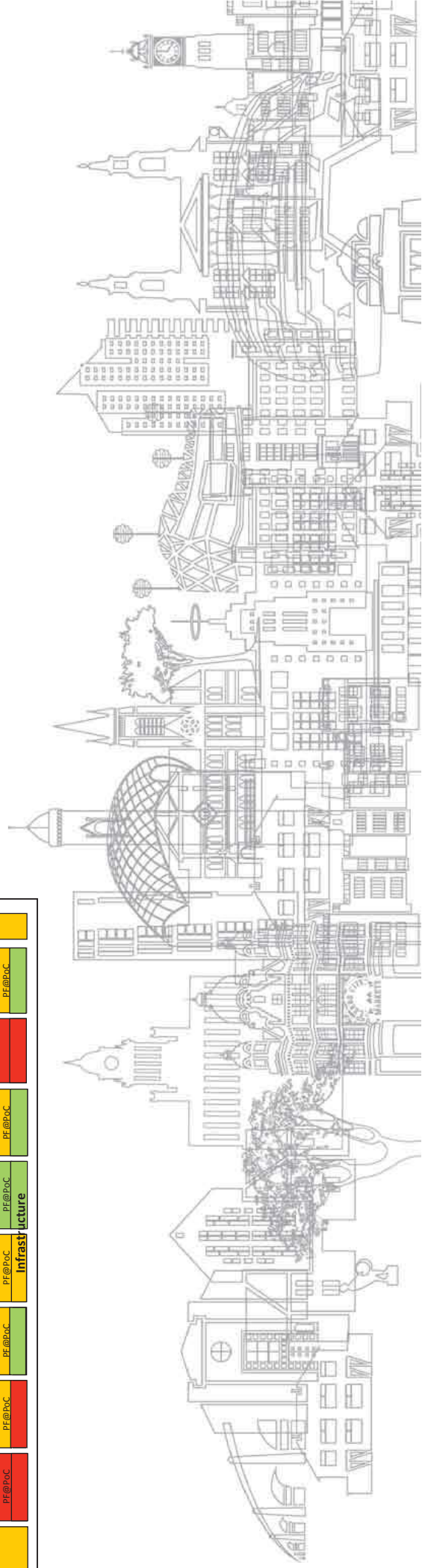
Given that Leeds has already made considerable progress in delivering a number of far-reaching digital support facilities for the city, for example the Leeds Care Record, **we have rated the following features based on the 'push' and investments required to deliver our ambition and not our current state.** This is illustrated diagrammatically as follows:



These features by STP 'gap' are summarised as follows:

Health inequalities gap: High-level considerations for how Informatics will contribute:

- To improve digital literacy skills for citizens to ensure that they are not excluded from technology-enabled healthcare solutions and technology enabled self-care opportunities;
- Continue to 'link' health and care data across sectors in order to undertake more sophisticated population and health needs assessment;
- Use and publish 'open data' to assist with health awareness and ensure our localities are well informed, for example air quality, transport links and usage;
- Build and develop more analytical skills that span sectors, utilising skills and capacity across organisations which will drive understanding of the issues in the health and care sector;
- Work with citizens to increase their understanding and confidence and as to how their data/information can be used to improve healthcare;
- Provide tools to support self-care/self-management, for example tele-health and tele-care;
- Work with the private sector to develop new consumer-based products to support self-care and self-management;
- Utilise and improve population stratification techniques and our ability to monitor cohorts;
- Engage communities with data that is meaningful to them;
- Provide public wifi access.



Care and quality gap:

High-level considerations for how Informatics will contribute:

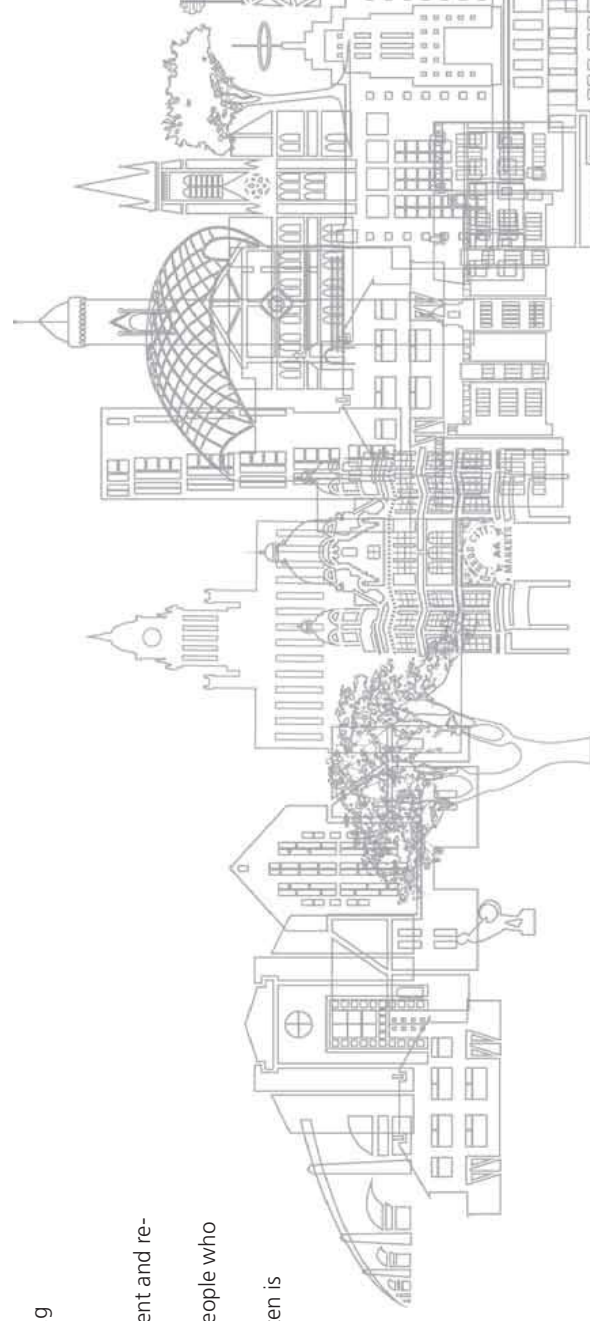
- Improve technology infrastructure within organisations to ensure reliability and adequate service support to cover extended hours and 7-day working;
- Provide health and care professionals with integrated decision support tools to proactively assist with the health and care provision;
- Provide facilities to enable health and care professionals to navigate pathways across sectors;
- Provide facilities to manage health and care workflow, especially across and between organisations and ensure technology is available to support service 'hand-offs' e.g. referral, discharge;
- Ensure Third Sector and AQPs etc. can access the NHS number, as required;
- Provide facilities that allow health and care professionals to collaborate. For example, Instant Messaging, Voice and Video. This will include the capability to provide clinical advice and guidance and facilities for effective Multi-Disciplinary Team meetings;
- Provide facilities to allow professionals to communicate with patients inc. patient online and video;
- Ensure health and care organisations have the range and maturity of specialist business and clinical systems within their organisations to provide 'paper free at the point of care services and can interoperate with other parts of the health and care sector;
- Design and develop technology support for 'new models of care' providers;
- Provide health and care professionals with an integrated view of health and care information across sectors, including various alerts to support direct care;
- Extend an integrated view of health and care for citizens across a wider footprint e.g. West Yorkshire urgent and emergency care;
- Exploit nationally provided technology facilities to provide specific clinical benefits – e.g electronic prescriptions (EPS2) and electronic referrals (eRS);
- Implement 'tele' technologies: -

- 1) Provided to citizens as consumer based technologies to enable them to be self sufficient and re-abled
- 2) Proactive "telecare" provided to citizens used to effectively monitor and make sure people who are at risk are safe and well;
- Provide technology to enable real-time feedback for providers on the services the citizen is currently accessing in the city;
- Provide technology to capture and share a single care plan;
- Provide specialist, high-tech solutions e.g. robotics etc.

Finance and efficiency gap:

High-level considerations for how Informatics will contribute:

- Continue to design and deliver city- or place-based solutions, exploiting the combined capabilities and resources across health, care, local government and academia;
- Work to move to one infrastructure footprint and service for the city – including voice, data, email, collaboration tools etc;
- Exploit nationally provided technology facilities to provide specific clinical benefits – e.g electronic prescriptions (EPS2) and electronic referrals (eRS);
- Deliver 'utility' technology where possible to drive down costs and use estate flexibly etc;
- Utilise private sector, independents, SMEs etc. to contribute to city inward investment;
- Work to progress an Open Standards approach to developing a Digital Platform for the city.



Digital maturity and Core Capabilities

Summary of current digital maturity

The following section summarises a national exercise that was undertaken in early 2016 to assess the digital maturity of the health and care providers in Leeds. The terminology used is that used within this particular methodology.

Readiness:

Strategic alignment, leadership, governance and resources are mature within acute and mental health sector. Although the informatics strategy is documented within community health there is less maturity in terms of dedicated internal informatics leadership, governance and resourcing.

There is a mature and well established Leeds city informatics strategy, city-wide governance and set of project initiatives which are jointly funded. The informatics programme is an enabling component of the city transformation programme (in the process of transitioning to the STP). The membership of the Leeds Informatics Board comprises of senior leaders, clinicians, CCIos and CIOs from across the city.

Capabilities:

Digital records, assessments and plans have advanced in all health and care settings. There has been significant growth in the use of digital records and the use of paper records is declining. Records are up to date, held in a structured format and can be accessed quickly and easily.

Transfers of care from acute health to primary and social care settings is higher than the national average, however the transfer of care from community health and mental health is less mature, although the use of SystemOne across Community and 70% of Primary Care supports the transfer of patient care through the shared record functionality. The development of e-referrals and internal workflow is common to all organisations.

Orders and results management is mature within acute care and community care.

Digital medicine management and optimisation is relatively low in maturity which is reflected at a national level, however the level of maturity within acute care exceeds the national average

Decision support capabilities exceed the national average across all health settings; the level of maturity within acute care is strong. The need for universal and standard decision support tools across the city has been identified as a key priority. Business requirements have been identified in some health and care settings. Advancement has been slow due to financial resource limitations.

Remote and assistive care technologies in a health setting are generally low in maturity which is reflected at a national level

Asset and resource optimisation is mature and exceeds the national average in both acute care and mental health. Community health is relatively immature.

The position on 'standards' is generally less mature than the national average.



Business Intelligence across the city is a priority. The requirements for information and data sharing are well formed and the production of linked intelligence is systematic. The further advancement of this initiative is also constrained by financial resource issues.

Enabling Infrastructure:

A strategy has been agreed across the city to standardise the technical infrastructure within the acute sector to improve resilience, performance, 24x7 and extended hours working across the city.

Leeds Teaching Hospitals NHS Trust has the most pressing infrastructure upgrade needs. Their requirements include resilient data centre capability, network improvements, single sign-on and improved performance for clinical users. The Trust has unsuccessfully bid for capital funds from the TDA/Monitor and work is underway to refresh a business case in the summer/autumn 2016.

Leeds City Council utilises the PSN network and has successfully pioneered a PSN to N3 connection. GP Practices all utilise the N3 network. This provides practice-to-N3 connectivity but not practice-to-practice connectivity that will be required for increased federation and new models of care.

As per our strategic approach, the city is looking to deliver 'place-based', 'utility' solutions in the future, enabling health and care users to work any-time and any-place within the city.

Summary position across the 7 Core Capabilities

Each health and care economy is required to make digital progress against 7 'core' capabilities to enable 'paper free at the point of care' operation by 2020. Those digital capabilities are:

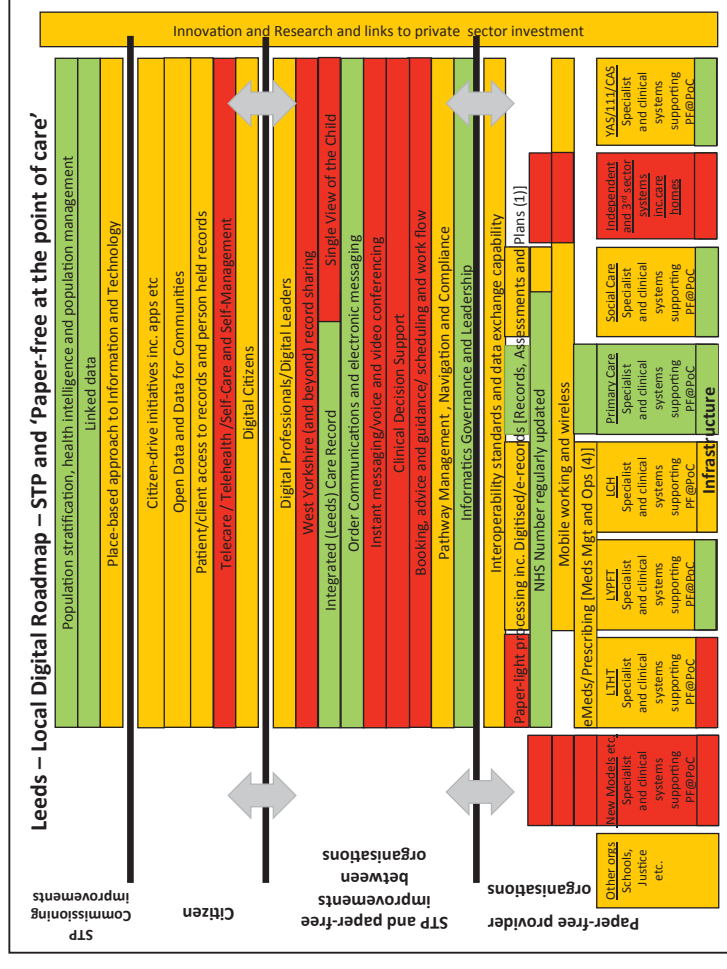
- Digital records, assessments and plans
- Transfers of care
- Order and results management
- Digital medicines management and optimisation
- Decision support
- Remote care and assistive technologies
- Asset and resource optimisation

The following assessment across the 7 core capability areas references both the provider view - as captured by the digital maturity assessments - and the city-view to enable transformation, as described in the Sustainability and Transformation Plan (STP).

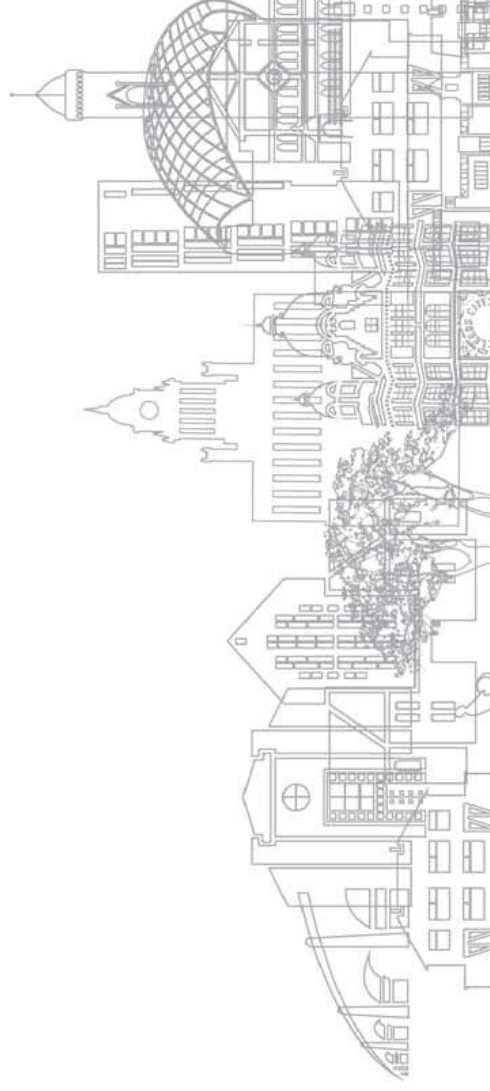
As essential supporting information to the 7 core capabilities required to be progressed, the following templates have been completed:

- Capability trajectory, showing the anticipated capability improvement from the baseline position over 3 years, and subject to the required resource capacity and capability.
- Capability deployment schedule over 3 years, and subject to the required resource capacity and capability.

The following diagram is an illustration that combines both aspects and represents our strategic way forward:

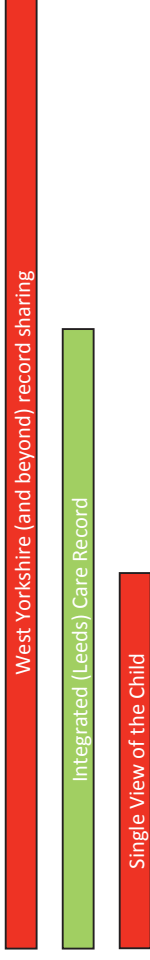


We have rated the above features based on the 'push' and investments required to deliver our ambition and not our current state.



Capability: Digital records, assessments and plans

Integrated city perspective:



Provider Baseline:

The level of maturity of formatted digital records for clinical notes, observations and plans in acute care and community health is lower than the national average; however these organisations have programmes of work to review and develop systems and processes to enable replacement paper records with digital records increasing the use of e-form capability and usage which is captured in the capability deployment schedule.

Mental health is very mature on these records being digital, in particular case notes are input directly into the patient management system. It is worth noting however that the current system in mental health has limitations to deliver interoperability so there are plans to procure an alternative that can deliver to the requirement for an integrated city-wide capability. Social care have semi-structured digital records.

The ability to access digital records from wherever they are needed is strong within acute care, however there is acknowledgement that the requirement to have a fit for purpose device at the point of care to enable viewing and updating of digital records is a challenge. Improving this position is a clear capability requirement in the deployment schedule. The updating of digital records is recognised as strong but this can happen after the event which is not always supportive of resource optimisation.

Access to and updating digital records from wherever they are needed in community health and social care is less mature with clear dependencies on digital network access and access to integrated information systems.

The ability to access a single source of digital information at the point of care, and input once to a single system at the point of care, is less mature and lower than the national average within all care settings. The key requirement across all providers to support delivery of an integrated patient record is a common thread through the capabilities in the deployment schedule.

Health professionals have access to information from other health care providers. Access to a consolidated view of patient information is mature and higher than the national average. Social Care has access to health information and health has access to social care information. Although the level of information being shared and accessed is higher than the national average (which is low) there is a programme of work through the Leeds Care Record to advance the data content and the number of professionals accessing the shared information system which is reflected strongly in the capability deployment schedule.

Patients are currently unable to access health and care data via secondary care but good progress

has been made on patient access to PatientOnline with approximately 15% of patients registered to use online services currently which is over the national target of 10%.

The delivery plan for universal capability shows clear ambition and activities to improve this position.

This position has significantly improved in Primary Care in Leeds over the last decade as a result of every GP Practice moving to one of two strategic systems; EMISWeb or TPP SystemOne. Record sharing is relatively mature especially using EDSM within SystemOne as this is also used by Community and the two hospices in Leeds.

Example showcase initiatives:

An integrated health and social care record called **Leeds Care Record** (currently view-only) has been developed and deployed in all health and care settings. The shared care record is continually being improved in terms of data content and usage. There are over 2000 active users in 5 core organisations and all GP Practices. This allows improved decisions to care for people in the appropriate settings and keeps patients out of hospital. For those patients in hospital Leeds Care Record allows health and care professionals to view the in hospital information and assist in patients being discharged.

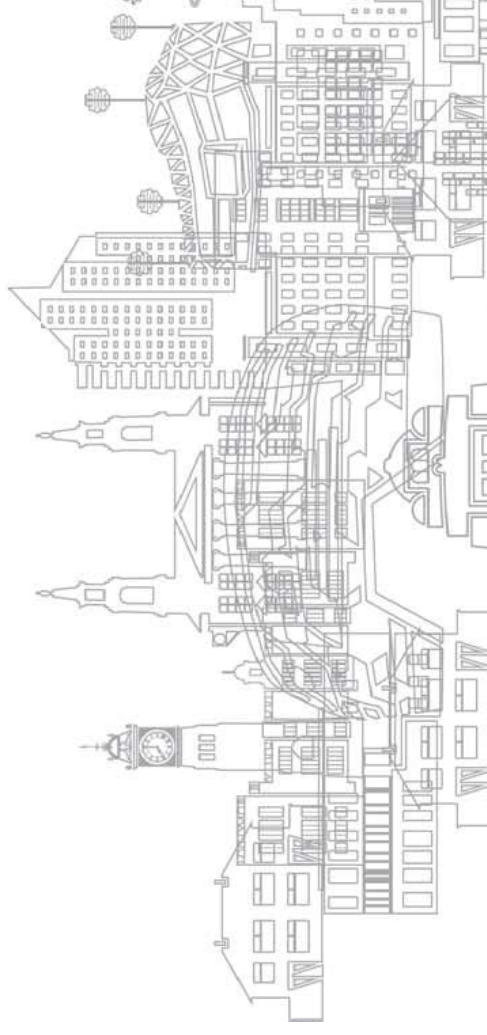
Leeds Community Healthcare is re-engineering the use of their core system to change from administrative use to clinical use as an **electronic patient record**.

Leeds Teaching Hospital NHS Trust have **consolidated** their **letter production**, storage and search facilities using a product called ePRO.

Adult Social Care has implemented a **new case management system**. **Children's Social Care** has implemented a **new case management system**. The improvement in functionality for professionals has led to better care and increased efficiency.

Strategic view:

Health and care providers in Leeds will operate paper-free-at-the-point-of-care. Information systems will use the NHS number as the common identifier. Information systems will use APIs and generate and receive messages from other systems. An integrated care record (Leeds Care Record) will provide a cross-organisational view of patient and client care.



Capability:

Transfers of care

Integrated city perspective:

Instant messaging/voice and video conferencing

Booking, advice and guidance/ scheduling and work flow

Provider Baseline:

The production of digital care summaries at patient discharge to GPs is mature with 96% of secondary care providers sending GPs electronic discharge summaries, of which 84% are received within 24 hours. The status of other structured electronic referrals for transfers of care is less mature, however, in terms of Social Care compliant Assessment, Discharge and associated Withdrawal notices 83% of referrals are being sent from the acute provider electronically to Social care.

The production of digital care summaries that are created in a structured format in secondary health and are shared with other healthcare providers in real time is more mature than the national level. These are also closely aligned to the AoMRC headings where appropriate.

The production of structured digital referrals for all categories of care which are automatically integrated into digital clinical workflows is lower in maturity across all care settings than the national level. Within secondary care there is also some pre-population of data to other systems.

Within community health the use of structured formatted referrals and care summaries is relatively immature although GPs who use SystmOne benefit from the ability to "task" community services with referrals and have access to the detailed electronic record through the sharing functionality. Within the social care digital system there is a case summary view.

In primary care, Leeds GPs receive a range of electronic messages, these include e-Discharge Advice Notes, Pathology and Radiology results and e-A&E discharge notes.

Example showcase initiatives:

The establishment of a **city-wide information governance steering group** overseeing the IG needs of the city to ensure security, consistency and improve best practice. The group has led the production of class leading Information Sharing and Data Processing Agreements for the integrated care record.

Integrated neighbourhood teams have been established in shared accommodation and have been equipped with technology which supports the joint care management of patients and service users. Tactical shared infrastructure has been implemented and strong information governance has enabled improvements in the transfer of care from one setting to another.

Colleagues within health can access the email addresses of appropriate staff in adults and children's care services and visa versa. **Secure email** has been implemented in all health organisations and in the local authority. This has improved the transfer of care and information security.

Strategic view:

There will be a consolidated view of care plans across the city. Pathway management and decision support tools will assist clinical decision making and transfers of care. Advice and guidance facilities will be available to ensure that all referrals are necessary. Professionals will be able to see the 'presence' of other professionals, and convert this into an instant message, telephone or video call. Universal booking facilities will be available. Information and data will follow any transfers of care, using open APIs between information systems.

Capability:

Remote care and assistive technologies

Integrated city perspective:

Patient/client access to records and person held records

Telecare / Telehealth /Self-Care and Self-Management

Citizen-drive initiatives inc. apps etc

Provider Baseline:

The maturity level of professionals and patients use of collaboration tools to support clinical consultations and advice is low in most areas except mental health which reflects the national level of 50%.

Maturity levels for remote monitoring of patients at risk of readmission are similarly low however there is a higher level of maturity in social care to support service users at risk.

The use of Patient Online as a means by which patients can manage their care through electronic booking of appointments, ordering repeat prescriptions and access to their GP record is increasing and Universal 'Capability J' delivery plan evidences activities to improve on the current position. This will include engaging with the GP Connect programme and GP system suppliers who are reviewing options to improve their service offering.

The 'Technology Fund 2' initiative, 'Ripple', will pilot a person-held record in 2016.

Example showcase initiatives:

We have tested a number of technologies for use with citizens. These have included technology to enhance citizen self-management of health and care, apps that interact with a patient's GP (e.g. managing acute pain) and those enabling people to live independently and tackle social isolation. The acute pain management app is also live but many tests and trials have yet to demonstrate the economic case for implementing at scale. **Assisted Living Leeds** is the most successful example of remote care technology. This is now a large operational service providing assistive technology aids such as falls and flood indicators.

Strategic view:

We aim to create the environment and encourage the technology market to respond to aspects of the citizen health and wellbeing requirement, for example, this could be the use of internet 'home hubs' integrated to near-citizen digital devices. We aim to do this via the establishment of a city technology 'test bed' to enable suppliers to work in a close-to-real environment. We will also encourage open standards for the sharing of citizen collected information with professionals and vice-versa. We will integrate near-patient testing devices with our Leeds Care Record. We will use social prescribing to increase the uptake of innovative approaches to health and wellbeing.

Capability: Orders and results management

Integrated city perspective:

Order Communications and electronic messaging

Provider Baseline:

The digital ordering of tests and consultations in a structured format across all health settings is strong and higher than the national maturity level. More development is needed in the areas of pre-population of existing data and assimilation of associated data.

Community health can positively identify patients through using barcoding technology prior to all diagnostic tests being performed. Requests received by diagnostic services are integrated into digital workflows. The results of tests and images for patients are available to city health and care professionals at the point of care.

These maturity levels are higher than the national levels.

The capability to create an alert for results that require acknowledgement is less mature.

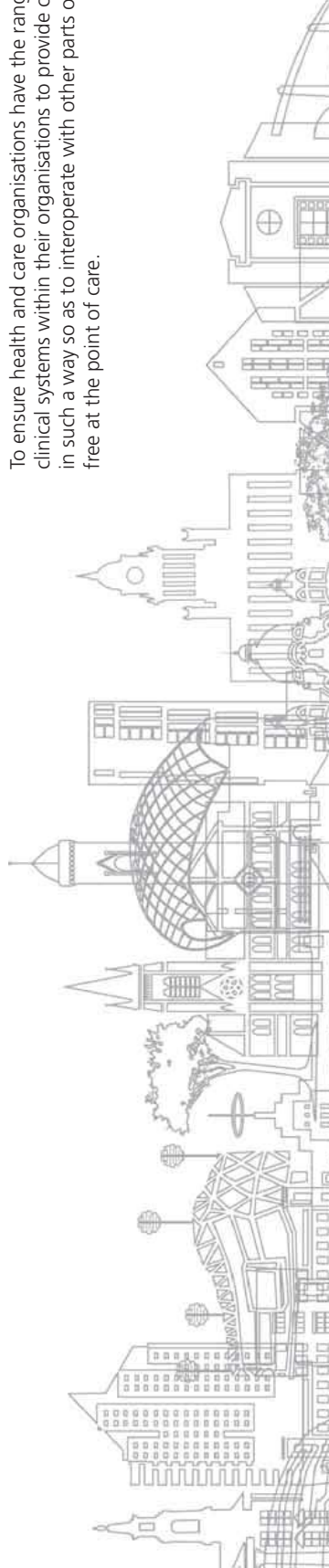
Within Primary Care universal technology features have been implemented that have enabled significant efficiencies; Ordering of tests and services using Sunquest ICE, electronic results reporting.

Example showcase initiatives:

A digital facility for **orders and results management** has been in place for several years across the Leeds Teaching Hospital and all GPs in primary care in Leeds. Making processes more efficient, improved clinical decision making and patient experience. The order communications systems is integrated within GP clinical systems.

Strategic view:

The breadth of services covered by an operational order communications facility will be expanded. The protocols for ordering (decision support) will be continually refined. Results, as well as other outputs such as images, will be available via Leeds Care Record.



Enabler: Standards

Integrated city perspective:

Interoperability standards and data exchange capability

NHS Number regularly updated

Provider Baseline:

Publication of the NHS Number on correspondence to support information sharing across the health setting is not established in all settings.

The use of SNOMED CT is not established and national levels are low.

Dictionary of medicines and devices is low in maturity and lower than the national levels.

The Academy of Medical Royal Colleges Standards for clinical structure of patient records is strong and stronger than the national levels.

The recording of patient end of life preferences with reference to the national standards in the community are higher than the national level of 14%.

Example showcase initiatives:

NHS Number: Excellent progress has been made on obtaining the NHS number in Leeds. **Adult Social Care** undertook the **Information Governance Toolkit** wide assessment several years ago (now completed council wide) and began tracing NHS numbers. The next step is to capture the NHS number in care records for both adults and children in real time from the PDS. This will replace the current use of the DBS. We will also ensure the publication of the NHS number on to adults and children's correspondence. This supports joined up care, speeds up access to information and improved records management and data quality.

Ripple: Leeds has led the way on a 'Technology Fund 2' programme to establish and promote the use of **open standards and open requirements** to support organisations outside Leeds undertaking digital care record initiatives. This programme, known as 'Ripple' has developed a demonstrator Open Source Integrated Digital Care Record Platform.

Strategic view:

To ensure health and care organisations have the range and maturity of specialist business and clinical systems within their organisations to provide core capabilities which have been implemented in such a way so as to interoperate with other parts of the health and care sector and deliver paper-free at the point of care.

Capability: Digital medicine management and optimisation

eMeds/Prescribing [Meds Mgt and Ops (4)]

Provider Baseline:

Currently the ability of healthcare professionals to see a complete digital view of medications and prescriptions is lower than the national average. In addition the ability to digitally prescribe medication is low and is not routinely performed except for chemotherapy.

That said, the secondary care hospital and the mental health provider are both engaged in a structured rollout of the same e-Prescribing and Administration electronic solution which utilises the same base formulary for prescribing, allowing for medicine optimisation and the establishment of prescribing protocols. This will see the baseline scores of both providers increase over the 3 year LDR period as inpatient wards and outpatient services are brought on line and digitally enabled processes are embedded. In addition this will deliver benefits to asset optimisation as the reliance on prescribing clinicians being in the same location as the physical drug chart is removed.

Community Health do not currently have an electronic prescribing and administration system as their clinician prescribing numbers are low, however it has been recognised that there are economies of scale benefits to explore by reviewing the above solution to understand if Community requirements can be encompassed to deliver commonality city wide.

Community Health and Social Care do have some visibility of medication order sets via Summary Care Record, where Role Based Access Control (RBAC) permissions are in place, this is enhanced through Leeds Care Record which provides access to GP prescribed medication. Medication prescribed by other providers will be increasingly visible as the e-prescribing / administration system use becomes widespread and available through the Leeds Care Record in a 'melded' view of the patient's medication from all health providers.

Social Care are low in maturity in the administration medicine management, however their focus is on ensuring they have information on prescribed medication including dosage and frequency which will be supported by the delivery of information within the Leeds Care Record which is accessed by Social Care professionals with the required permissions

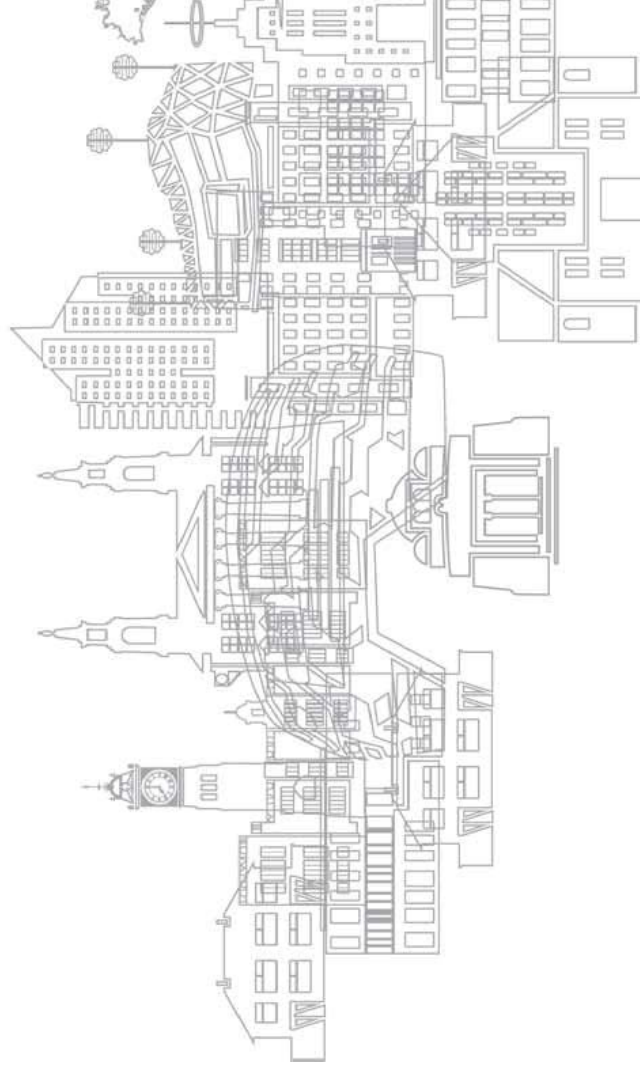
Within Primary Care excellent progress has been made on e-prescribing 2 (EPS2). Of the 105 GP Practices within the Leeds footprint, 95 are Release 2 compliant, this is 90% against the national average which is 81%. In addition, all but one of the community pharmacists in Leeds is Release 2 compliant. This is evidenced within the universal 'capability 1' delivery plan with structured ambitions and delivery activities identified to progress in particular repeat dispensing within the national EPS Phase 4 pilot.

Example showcase initiatives:

Excellent progress has been made in implementing ePrescribing 2 in Primary Care. Practices have experienced considerable efficiencies which is evidenced by the average percentage of electronic to paper scripts across the 3 CCGs currently at 50% against a target of 40%. There are clear plans in place to improve this baseline within GP and Community Pharmacists evidenced in the delivery plan for universal capability 1.

Strategic view:

Secondary Care hospitals and the mental health provider will be using electronic facilities for near patient prescribing. 'To take home' electronic messages will be sent to GPs. Both secondary and primary care prescribing will be reflected in the Leeds integrated care record. Various medicine regimes will be reconciled. The accessibility of this information by the appropriate professionals improves the management of care, the utilisation of professional clinical time by enabling remote access to electronic prescribing and administration records, reduces medicine costs through identified formulary use and reduces medication error improving clinical and patient safety.



Capability: Decision Support

Integrated city perspective:

Risk Stratification, health intelligence and population management
Linked data
Clinical Decision Support
Telecare / Telehealth / Self-Care and Self-Management

Provider Baseline:

The maturity of capability for health and care professionals to receive alerts to the existence of patient preferences, specific patient risks and where there has been a deterioration of their condition is strong and much higher than the national levels.

Reminders about overdue care actions and chase ups for missing information exist in part and at a higher level of maturity than the national level.

The delivery of an electronic prescribing and administration system in secondary and mental health will enhance the delivery of automated alerts which will highlight patient specific alerts and allergies in patient context and will reference potential contra indications with existing medications. The solution also provides for electronic access to decision support tools for prescribing within the application without additional navigation.

Decision support currently provides support to the discharge process and maturity levels are higher than the national level. The LDR capability deployment schedule shows a clear capability delivery priority as encouraging and increasing access and management of a shared patient summary record through enhanced usage and richness of data in the Leeds Care Record, which will enable effective and proactive joint decision making through collective provision of decision support information. This will support delivery of enhanced patient flow through care settings.

GP core clinical systems have aspects of decision support and strong workflow features. This includes implementation of the EPaCCs template to ensure that patients on a palliative care pathway can express and change their end of life preferences. Universal 'capability H' delivery plan confirms the excellent progress that has been made and the activities to include this information in the Leeds Care Record to make this available for all care professionals.

Child Social Care is implementing Child Protection Information Services (CP-IS) as part of the national roll out. Universal capability G delivery plan evidences the ambition and activity to ensure this information is available through both CP-IS and Leeds Care Record to care professionals in particular in urgent care settings.

Example showcase initiatives:

Leeds Care Record (LCR) has clear plans in place in 2016/17 to deliver additional patient alerts including an indicator that a patient is in the top 2% of patients with a care plan in place and alerts to learning disabilities. This is evidenced within the LDR deployment schedule capability deliverables.

Leeds GPs can see live ward **electronic whiteboard** details of their patients in hospital or lists of patients recently discharged through the LCR. Electronic messages from Leeds Teaching Hospital automatically appear in GP clinical system workflows. General practice use facilities such as the 'frailty index' and make use of proactive clinical templates.

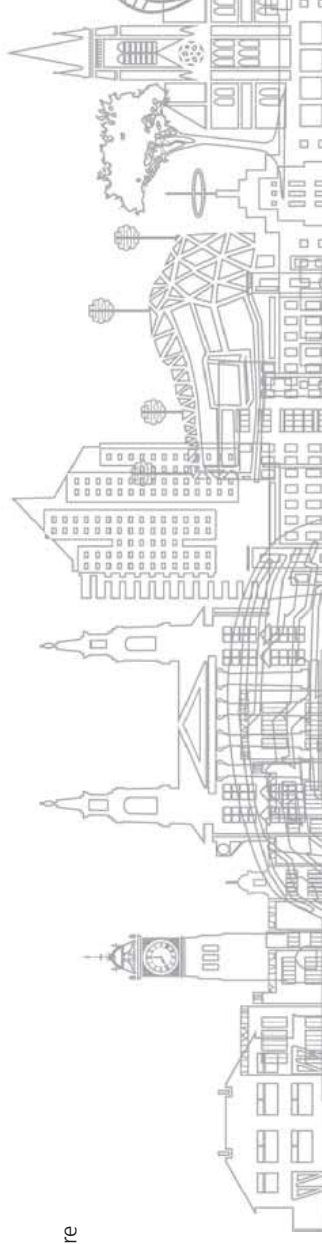
GPs and secondary care use **pathway guidelines** which are available through the Leeds Health Pathways from a dedicated website at <http://www.lhp.leedsth.nhs.uk/>



Leeds Intelligence Hub: Separate from clinical decision support Leeds has made excellent progress with commissioning decision support. Using pseudonymised linked data Leeds has some powerful examples of improved commissioning decisions and evaluations. Significant analysis has been delivered supporting transformation initiatives and city priorities. This has enabled the health and care system to evaluate the impact of changes and identify opportunities for change and driving efficiencies. The Leeds Intelligence Hub compares variation in care across the city's neighbourhoods and begins to understand why and how to address unwarranted variation. The insights generated have provided a totally new level of dialogue and discussion across the city from city-wide leadership groups, the Health and Wellbeing Board, urgent care boards and most organisation's senior management teams.

Strategic view:

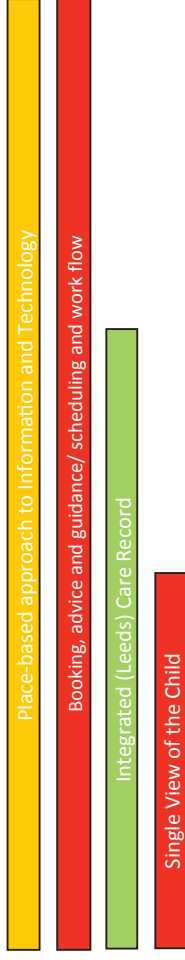
Facilities that are currently passive will become proactive. Clinical decision support facilities will move from within organisations to a city-wide collective provision with access available to all organisations and with all organisations providing input. We will design our Leeds Care Record to use real-time feeds from 'tele' facilities such as near patient testing devices. Capabilities such as booking will move from point-to-point to 'open' facilities to support a wide range of booking.



Capability:

Asset and resource optimisation

Integrated city perspective:



Provider Baseline:

Digital systems are used in all secondary care settings to monitor bed utilisation; maturity levels are consistently higher than the national levels.

Digital systems are used to track patient flow in acute and mental health; there is less maturity in community health and social care. The Acute provider is deploying GS1 to allow assets to be tracked robustly through the secondary care organisation to optimise their use and ensure they are available at the right place at the right time for delivery of care. The ability to track patients robustly through their journey through the Trust will also be managed more effectively to signpost to relevant departments and to improve patient flow.

Staff rostering is digitally managed in acute, mental health and social care although weaker than the national level in community health. However, within the deployment schedule there are capabilities with planned delivery of e-rostering solutions in both the mental health provider and Community which will support the appropriate health and care professional being in the right location at the right time to make best use of professional resource.

The uploading of data from devices is mature in acute but weak in other settings. This is dependant on devices being fit for purpose, managed and supported effectively.

Example showcase initiatives:

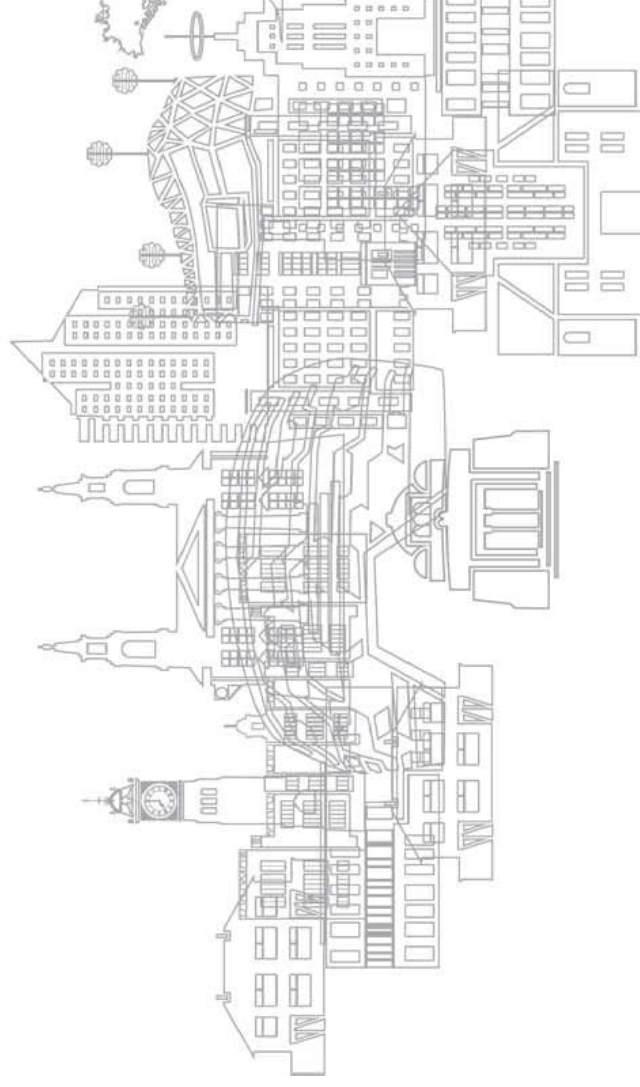
As described in Section 1 Leeds has gained approval to take a **city-based approach to the delivery of informatics** in terms of integrated infrastructure, planning and delivering integrated business/clinical systems and innovations. This will eradicate the multiple and diverse initiatives which come from different parts of the health and care system that use up resource in an unplanned way and often confuse. It will also ensure that digital programmes and projects are aligned fully to an agreed whole-system outcome described in the health and wellbeing strategy, STP and LDR.

The **Leeds Care Record** is proving valuable in terms of avoiding phone calls between sectors to access additional clinical information.

Mobile working initiatives have delivered efficiencies in the use of accommodation and office space. Desk utilisation has reduced to 60% in areas of the system where the implementation of mobile working has been fully embedded.

Strategic view:

We will deliver a city (or place)-based approach to technology infrastructure enabling an any-time, any where, any-place capability for professionals. We will use informatics resources as effectively as possible. We will improve the technology infrastructure within organisations to ensure reliability and service support to cover extended hours and 7 day-working. There will be a full review of estate assets across the city. This will underpin the place-based approach from a technology perspective, combining the infrastructure offer for efficient service delivery. We will deliver 'utility' technology where possible to drive down costs and use estates flexibly. We will utilise the private sector, independents and SME's etc to contribute to city inward investment.



Enabler: Infrastructure

The city has varied levels of infrastructure maturity. Leeds Teaching Hospitals NHS Trust has the most pressing infrastructure upgrade needs. Their requirements include resilient data centre capability, network improvements, single sign-on and improved performance for clinical users. Public wifi access is relatively strong but weaker in the acute sector. The use of mobile devices is establishing itself in community health with a concerted programme of work to deploy portable devices to mobile staff, but more mature than the national level in acute and mental health.

Single sign-on is low in acute and community but higher mental health. The time it takes to log on is relatively high across the health settings, and the maturity in this area is lower than the national levels.

Software approval and management is mature.

IT Service Desk standards and management processes are weaker in acute and community health, but very strong in mental health.

Disaster recovery processes are weaker than the national maturity levels.

Recommendations made by the city Shared Strategy, Architecture and Commissioning group include:

- Develop a business case for shared data centre facilities
- Develop 'platform as a service' for infrastructure and desktop services that can be delivered to current and any future organisations
- Review skills and resources across the partner organisations that can be shared
- Build on the community assets which are a strength in the city
- Provide a modern, up to date, secure and resilient provision for all partners
- Provide extended hours, evening and weekends for incident management
- Provide support to professionals needing secure access to digital systems from any required location on the appropriate device
- Utilise collective buying power across the city partners to achieve best value for money

Example showcase initiatives:

The sharing and linking of data networks has allowed **integrated neighbourhood teams** to operate across health and care in new or revamped locations; this has reduced the cost of installing separate data lines. Integrated teams are able to occupy health premises and visa-versa, which improves multi-disciplinary team working and care management.

The delivery of improved **wifi for flexible and mobile staff working**. Improved public access to wifi in public buildings.

There is an ongoing review of the current infrastructure supporting integrated teams which will be followed by the provision of joint solutions such as scanning, printing and wifi. Improvements in hospital social work access to information and technology. The provision of access to adult social care systems on health devices.

Implementation of the **public sector network (PSN)** in health and care has offered versatility and achieved efficiencies. Leeds led the national pilot to connect the dedicated NHS network (N3) to the public sector network (PSN). This link provides access to health systems and information for Public Health staff, access to the child protection information and access to the NHS Number. These initiatives have increased integration opportunities and increased efficiencies through flexible working.

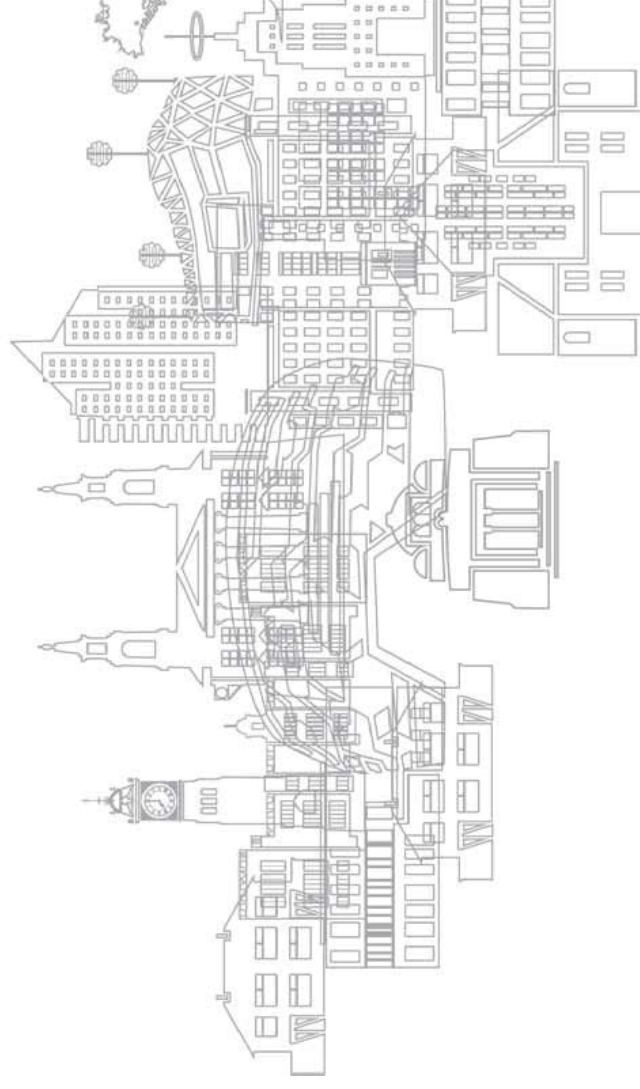
Implementation of **secure email** for all health organisations and the local authority. In addition, colleagues within health can now access the email addresses of appropriate staff in adults and children's care services and visa-versa. This has improved the speed of communications, improved information security and reduced data security breaches.

Leeds is a 4G city and the University has delivered an international facility called 'eduroam' which has the capability to be federated with public sector w-fi.

The university and the hospital trust have secure data and telephony gateways between the academics and the acute trust.

Strategic view:

Health and care professionals will be able to access their required systems any time and any place within the city, including via mobile devices. The infrastructure underpinning the city informatics strategy will be secure, reliable and responsive. Citizens will have access to universal facilities such as wifi in key areas such as some city-centre open spaces, public buildings and GP surgeries. People will increase their level of digital skills to access such services.



Universal Capabilities

Summary position across the 10 Universal Capabilities

Every local health and care system is expected to make early progress on 10 universal capabilities, demonstrating clear momentum between now and the end of March 2017 and substantive delivery by end-March 2018.

A separate template sheet has been completed for each of the 10 universal capabilities. Each is described as a 'capability delivery plan' and has significant detail in terms of baseline, ambition, key activities and evidencing progress, therefore we have not undertaken a point by point review as per the 7 core capabilities in this narrative. However as Leeds is in a good position to make the required progress we have provided examples of some areas where we have made notable progress, as well as some areas where more work is required.

Why Leeds is well placed to succeed in implementing the 10 universal capabilities:

Leadership: For many health economies there may have been some break in continuity between the Informatics leadership that existed within a Primary Care Trust and the new arrangements put in place at the establishment of Clinical Commissioning Groups. Fortunately Leeds had the foresight to establish a senior Informatics leadership arrangement at the outset on behalf of the 3 Leeds CCGs. This included the unified oversight of the IT provision for GP Practices. This CCG/General Practice leadership arrangement has now been supplemented with clarity on leadership and a structured way of working across the city.

Technology capability: Leeds has significant development experience and capability in technologies that support integration. This has enabled the Leeds Care Record to go beyond some national facilities such as the Summary Care Record. This development, which utilises integration and messaging capability, allows messages to flow in excess of those recommended nationally which can be viewed across health and care settings citywide.

City-wide working: Excellent arrangements have been in place for several years to ensure that the strategic informatics agendas of health and care organisations in Leeds are aligned, and aligned with the business/clinical agenda. This has meant that facilities such as an e-Discharge Initiation Document between health and adult social care is in place because of the business need that became apparent several years ago.

Engagement with General Practice: Through effort and good relationships we have many GP Practices in Leeds that continue to be willing to trial and then champion national technology facilities such as PatientOnline and Electronic Prescribing.

All of the above has meant that good momentum has been maintained in most of those areas that fall under the, now identified, 10 universal capabilities. Below are 2 examples of good practice and an example of where more attention is required.



Significant progress:

Example 1:

Universal Capability - 'Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions'.

Maturity view:

Leeds led the way in enabling all GP Practices to use the Summary Care Record [SCR] (100% contribution). This facility was used intensively in secondary care, with Leeds Teaching Hospitals being one of the top SCR consumers in the country. SCR was very much seen as a precursor to the Leeds Care Record, a secure, multi-organisational view of multi-organisational health and care data. Leeds Care Record is in its 4th Phase of development with over 2000 active users. As a basic this view includes GP-prescribed medications, patient allergies and adverse reactions.

Example showcase initiatives:

Leeds Care Record, including an agreed pilot with 111 nurses specialising in palliative care and mental health to allow access to the Leeds Care Record. This will inform design work across West Yorkshire to support Urgent and Emergency Care.

Strategic view:

The Leeds Care Record continues to be an essential part of the Leeds Informatics plan, although there are a number of challenges in terms of strategic next steps. These include:

- Delivering capabilities to move from a passive view record to a proactive tool for decision support
- Consideration to 'write facilities' to the LCR
- To deliver a future proof solution, a strategic approach to development is required i.e. in-house, a partnership or a city-developed asset

Capability deployment:

See 'universal capability delivery plan'.

Example 2:

Universal capability - 'Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care'.

Maturity view:

Acute Care for Leeds Adult Social Care receives on average 750 referrals per month. ASC's engagement with partners to work effectively to ensure social care receive timely electronic notices has been successful to date and has resulted in 83% of referrals currently being received electronically from the secondary care hospital to a single point of urgent referral (SPUR).

The SPUR is a multi-disciplinary team who have access to Health and Social care systems including a system to support police custody related calls. This means that SPUR can effectively receive and deal with in excess of 2,500 referrals on a monthly basis to ensure a joined up response to urgent requirements.

Example showcase initiatives:

The achievement of 83% of timely electronic transmission of notices from the acute hospital provider to social care.

Establishment of SPUR which is a multi-disciplinary team made up of both registered and unregistered workers from Joint Care Management and Intermediate Care Teams to deliver a Single Point of Urgent referral. This approach supports the STP initiatives of rapid response in times of crisis to optimise response and use of resources effectively.

Strategic view:

All 100% of Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices will be sent electronically from the acute provider to local authority social care within the timescales specified in the Act through coordinated activities to engage with out-of-area hospitals and convert the remaining non-electronic fax transmissions to the electronic solution to support SPUR coordination.

Capability deployment:

See 'universal capability delivery plan'.

Further progress required:

Example:

Universal capability - 'GPs can refer electronically to secondary care'.

Maturity view:

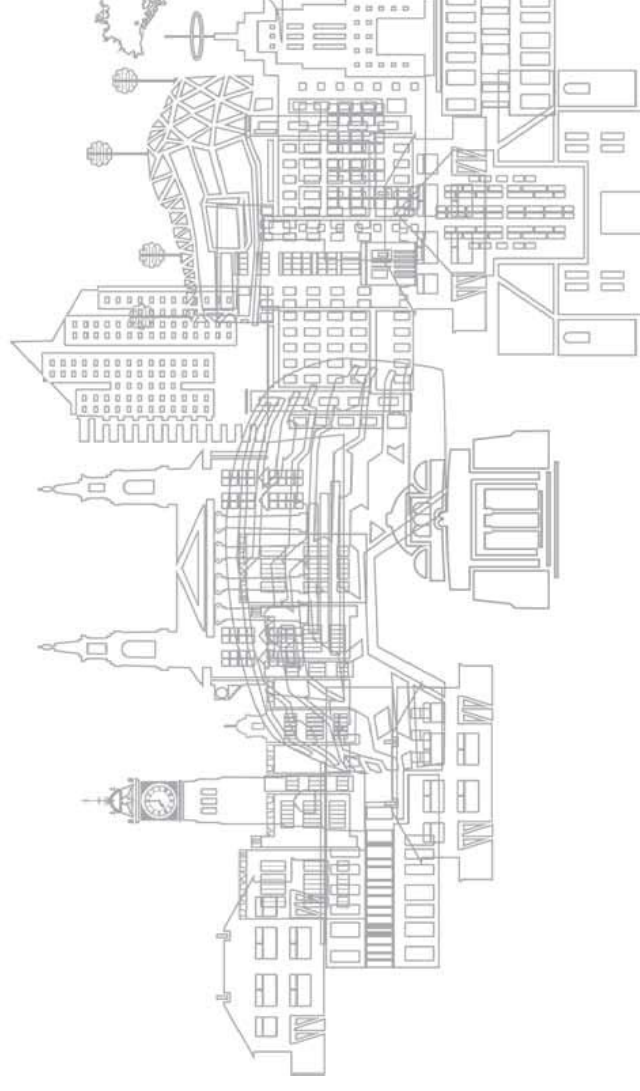
Whilst Leeds has managed to maintain a reasonable position with regards to e-Referrals it is fair to say that city-wide coordination is less robust than say 3 years ago. Our booking rates are lower than they were 3 or 4 years ago. Much of this is due to a problem with slots not being available in some specialities at the time of booking, leading to what is known as 'appointment slot issues'. Leeds Community Healthcare has made some good progress with becoming directly bookable for non-consultant led services, but resource gaps has led to this work slowing down. All GPs use the new eRS system to some degree but we have to address aspects such as advice and guidance and a pressure to shortcut processes.

Strategic view:

We will confirm the current place of eRS in the city. In the longer term we will look at open APIs for booking to create a more generic and 'open' booking facility. We will re-establish improvement coordination of eReferrals across the city and explore the facilities for advice and guidance and how this and eReferrals can become closer to pathways guidelines.

Capability deployment:

See 'universal capability delivery plan'.



Other enabling factors

Sources of funding

The Sustainability and Transformation Plans describes the underlying financial position and plan for the city and the need for significant recurrent savings to be delivered. However, it also recognises the role of informatics in enabling smarter working and service transformation. There will therefore need to be further investment in digital over the next 5 years as a means of delivering savings, efficiencies and improved quality elsewhere in the health and care system. At the same time there is an expectation that the efficiency of informatics operational services will also improve, delivering internal and collaborative savings across technology departments within the city. We expect any new investment to be multi-sourced over a multi-year timeframe. Leeds has a good track record of securing external funding and has the expertise to continue to do so.

Anticipated sources of funding:

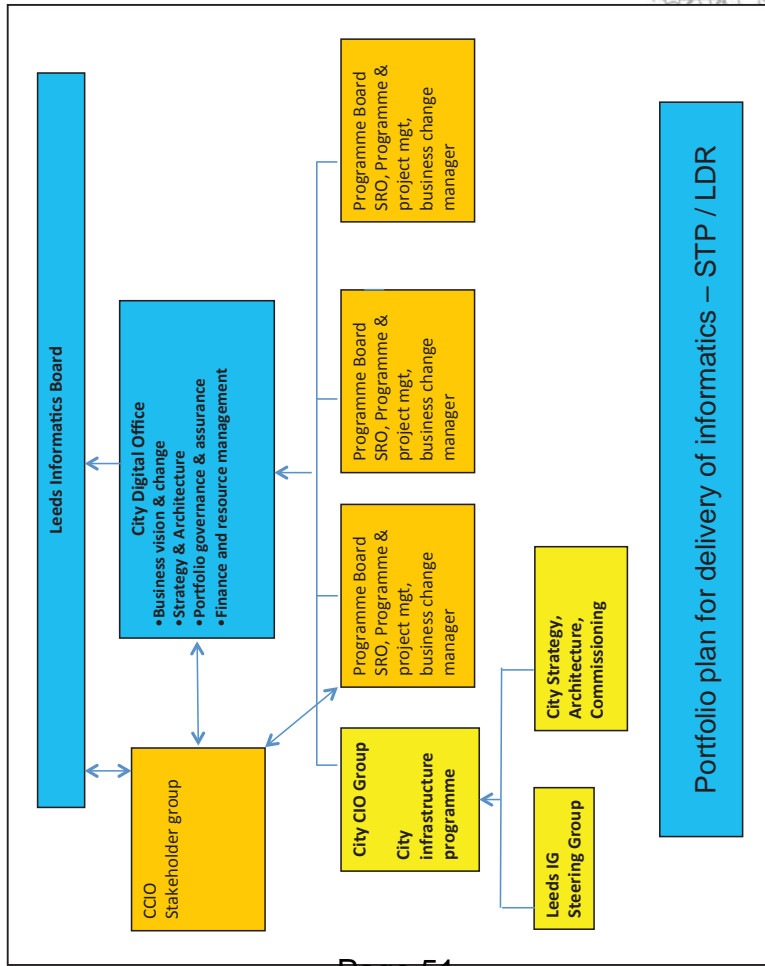
Providers	Existing internal revenue budgets
	Efficiencies on internal revenue budgets
	Access to internal capital
	Access to external capital
	Collaboration with the private sector
	Provider direct access to NHS National Information Board funding
City	City access to NHS National Information Board funding e.g. Local Digital Roadmap
	Access to other NHS funding e.g. Vanguard, Estates and Technology Transformation Fund, Integration, Pioneer funding
	Better Care Fund
	Collaboration across providers
	Collaboration with the private sector e.g. via an Innovation Test Bed
	Access to international funding sources



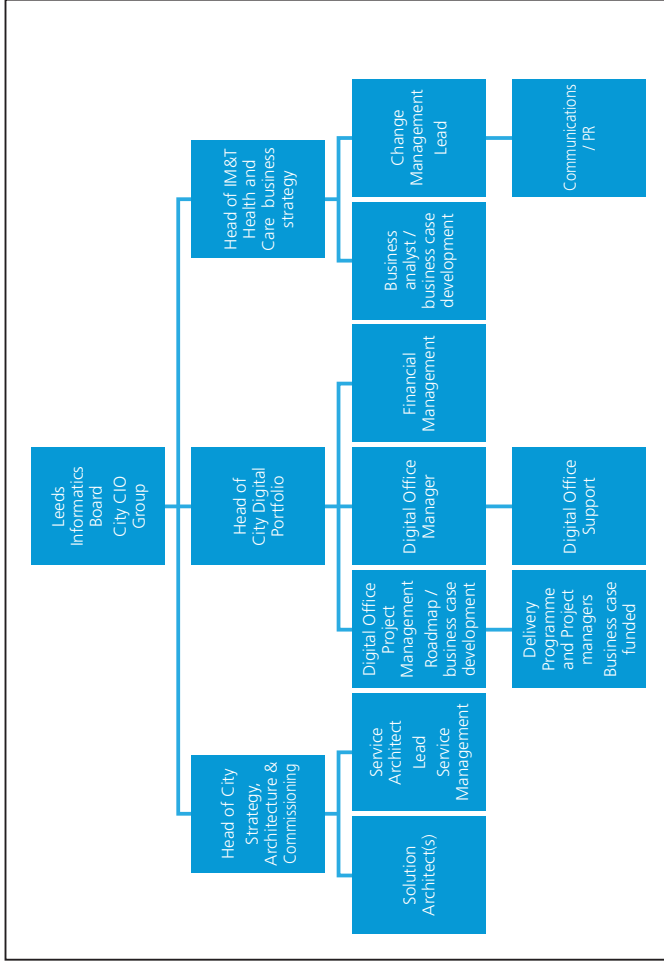
Governance

Strategic City-wide governance arrangements are established and provide assurance on the delivery of digitally-enabled health and wellbeing outcomes in Leeds.

Accountability for delivery of the Local Digital Roadmap and the associated digital change programme is delegated to the Leeds Informatics Board (LIB). This Board consists of a mix of senior leaders, clinicians and senior informaticians. It is chaired by a senior clinician; a GP and Clinical Chair of North Leeds CCG:



We are currently designing the anticipated city capacity and capability structure to support the delivery of the Local Digital Roadmap. Part of this resource plan may be a changed focus of some existing staff:



Change and benefits management approach

As a city, we are committed to continuous learning and improvement across our health and care services. As such, Leeds uses the appropriate change management models and approaches to deliver real business transformation to working practices and to bring about improved outcomes for the people of Leeds.

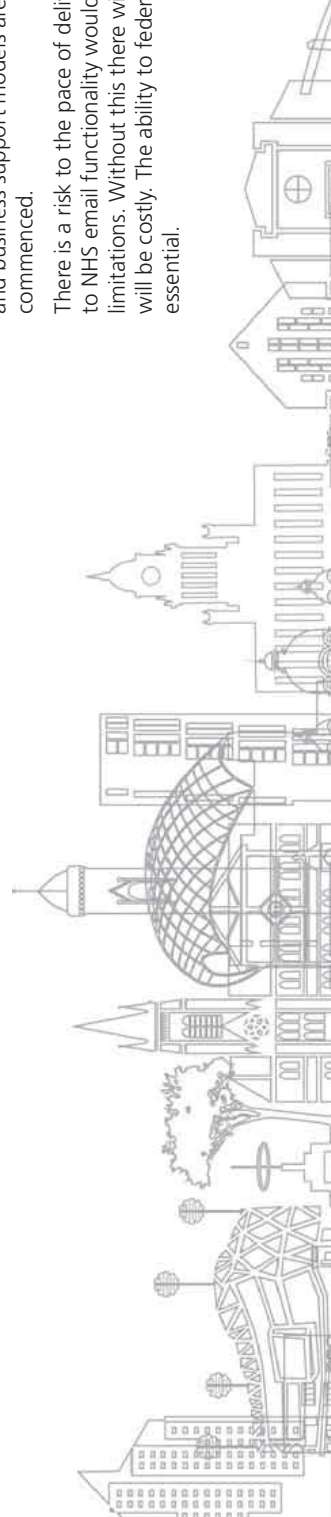
Different methodologies are used depending on the scale and the scope of the change required, from a "light touch" in-house approach, for example Leeds City Council's PMlite methodology, to more radical and nationally recognised models such as the Sustainable Improvement Team's 8 element Change Model. There is an integrated Programme Management Office for Informatics in the city. Additionally, individual organisations in Leeds have in-house project management offices and use recognised approaches to project management such as PRINCE and the Life Cycle / Gateway process. We will look to appoint a change and benefits management expert dedicated to the delivery of our Local Digital Roadmap.

With regard to business change, we recognise the importance of taking the clinicians with us on the journey. Staff engagement is critical to our change management work. For example, Leeds is leading on a digital literacy project for the health and care workforce, to enable them to make the most of the new technologies available and share the benefits of this with patients and service users.

We are uniquely placed through our partnership working and 'one city' Informatics leadership approach to access national and international support to bring about the changes required. For example, Leeds Teaching Hospitals Trust, is working with the Virginia Mason Institute. This approach supports them to apply 'lean' principles to increase patient safety, quality of care, value and efficiency.

Leeds identifies and deploys approaches to benefits management and measurement at the outset of any project, benefits and resources are planned using the appropriate tool to the scale of the project.

Progress is tracked continuously to ensure ongoing service improvement and value for money. In terms of measuring health and care effectiveness of service changes, Leeds has an integrated intelligence hub that works on behalf of the city and uses tools such as CareTrak to establish baseline data, predict and model change and measure progress. Academic evaluation is also built into the core of major projects. Listening to the views of staff, patients and service users to gather qualitative evidence of benefits is also crucial to measuring change and identifying barriers to realising benefits in the Informatics arena.



Risks and issues

We recognise that there are many rate limiting factors around people, processes and technology.

The pace of delivery of the digital roadmap is dependent on:

- Funding
- Sufficient staff with knowledge and expertise in the required portfolio roles
- Capacity for change across the system
- Signed-off digital requirements
- A variety of external dependencies
- Access to stakeholders and stakeholder leadership
- Clinical champions
- Technology

We have covered an element of risk and rate limiting factors within the locally defined attributes of the 'capability deployment schedules' headed 'Confidence; high, medium or low', against each capability.

In addition, the impact on the delivery of the capabilities within the Capability Deployment schedule, has been used to inform the Capability Trajectory scoring template. This trajectory assumes that funding can be secured. If this is not the case then clearly those maturity scores will not be achievable, either in totality or at the required rate.

The delivery of infrastructure at pace, which is robust and resilient, is a key dependency on delivering the Roadmap. The Leeds Teaching Hospitals NHS Trust (LTH) has the most pressing infrastructure upgrade needs. Their requirements include resilient data centre capability, network improvements, single sign-on and improved performance for clinical users. The change includes a step change in both technology and the service management policies and procedures to support the service delivery.

The step changes to deliver resilient infrastructure for the city includes:

- The establishment of strategic city-wide governance
- A full review of the current infrastructure and support models
- Identification of the gaps and recommendations for unified solutions.

Leeds has advanced on these activities, the options and recommendations on the technical solution and business support models are under consideration. The production of the delivery plans has commenced.

There is a risk to the pace of delivery of effective collaboration technology. Local Authority access to NHS email functionality would resolve the current city-wide communication and collaboration limitations. Without this there will be a delay in the development of alternative options which will be costly. The ability to federate across all organisations including the Local Authority is also essential.

Further rate limiting factors include:

- Access to the child-protection information system through the public sector network, with a bi-directional flow to be investigated.
- PSN to be accessible by the acute trust to support a multi-agency approach
- N3 circuit reduction
- PSN Alpha replacement and Leeds access to the Demographic Batch Service (DBS) through this route
- Agreement and implementation of a new generation national IG toolkit
- Addressing the cybersecurity agenda

A key element of our approach to minimising risks the arising from technology is the focus we are placing on good governance and the establishment of a common Strategy, Architecture and Commissioning function for the city. Our aim is for the adoption and usage of open and common standards as reflected elsewhere within this Roadmap. We see this as a fundamental construct in our wider approach to mitigating risks from technology in terms of ‘future proofing’ the city. As such, we will ensure that, as far as possible, GS1 standards are written in appropriately to our stated requirements as deemed necessary.

Resources

We recognise that resources, both financial and people capacity and capability, are essential to delivering this Roadmap. A city-first approach to Informatics delivery seeks to eradicate the multiple and diverse initiatives which come from different parts of the health and care system that use up resource in an unplanned way and often confuse. It will also ensure that digital programmes and projects are aligned fully to an agreed whole-system outcome described in the health and wellbeing Strategy, STP and LDR.

Such an approach will also help to develop and align our Chief Information Officers and Clinical Chief Information Officers.

We will also focus on building and securing more holistic analytical skills and facilities that span sectors, utilising skills and capacity across organisations.

The proposal for the establishment of a new Digital Portfolio Office is outlined in this document. The benefits include the economies of scale achieved through the sharing of expertise, standardising technologies and ways of working. The support functions will be streamlined to reflect shared infrastructure and technologies.

The process of developing the digital roadmap has exposed the City-wide plans to achieve paper-free at the point of contact. Cross cutting initiatives have been clarified and the strategic vision for integrated working has set the direction of travel. The design and development of the STP sets the focus for future digital enablement. The alignment of these activities provides greater control in terms of the effective use of resources.

Digital Literacy Programme: Leeds has commenced a digital literacy programme, the vision being to help health and care practitioners develop digital skills and confidence so they can make things better for people who access their services. We will also have a structured approach to improve digital literacy for our citizens.

Leeds Health and Care Academy: Leeds will support the establishment of one workforce for the city through collaboration between our universities and health and care employers, and establishing

a workforce Academy for Leeds. This will:

- Unify the training for a care workforce which has the required levels of digital literacy
- Provide efficiencies and a shared approach to delivering health care across various bodies including increased use of virtual facilities
- Enable training future health care providers e.g. new models of care including digitally enabled self care
- Assist with understand the funding landscape for training future professionals
- Provide a rapid response to workforce training needs including training in digital technologies

Innovation for Leeds

The delivery of the city’s ambitions to be the best for health and social care requires the development of both systems and culture which embed innovation. It is recognised that supporting infrastructure will be required to ensure these priorities are realised and will include deployment of the city’s Universities as integral to mainstreaming of innovation into service delivery. The Leeds Academic Health Partnership has been established to create an environment for solutions to be created and accelerated through collaboration and partnership across academia, strategy and practice. It will ensure current ‘assets’ are deployed to accelerate precision medicine including system flow capabilities, diagnostic capabilities and personalised and patient centred care.

The innovation programme seeks to develop a deep understanding of the challenges patients and clinicians are experiencing, including their use of technology, and then redesign pathways to identify how technology can be an enabler. The programme will use this understanding to provide a framework to then ‘test’ innovative products and services developed by collaborative partners which have been designed to improve population health and wellbeing. This programme provides the supporting infrastructure and access points for collaborative partners to develop innovations, promoting product and service development for the Health and Social Care market

The programme will operate the following work streams:

- The acceleration of the delivery of the Leeds City Region digital platform which is an integrated set of technologies that provide the structure to deliver joined up health and social care data that connects services, channels, systems and provides the foundation for sharing information to provide better care.
- The gathering of information to develop a deep understanding the challenges that patients, service users and clinicians are experiencing in the NHS and Adult Social Care with an initial focus on diabetes and frail elderly. The information will allow us to understand their use of technology, and then carry out pathway redesign, identifying how technology can be an enabler. This information can then be used to create a call to market for products, innovations and services that specifically target the issues identified and are supplied by SMEs from across the UK. This work will also help to accelerate the cities digital literacy priorities.
- The commissioning of innovation projects. The first stage of this will involve a call to market based around the needs identified above. NHS and Social Care will act as innovation hosts who will meet innovators at a series of networking events. This process aims to bring together innovators who can offer the greatest potential to improve health outcomes. Where there is scope for a collaboration the host and the innovator will be invited to submit a proposal to the commissioner fund, which will provide finance for implementation and training.
- Quality assurance and evaluation.

Working with our citizens

In Leeds, engaging and communicating with citizens is crucial to ensure that their views are at the heart of the work to help make the city a better, healthier place in the future.

Using and sharing information about citizens underpins this ambition yet there is often hesitancy around sharing information, even when this may lead to improved health outcomes and reduced health inequalities. Involving citizens in the discussion has been part of the work from the beginning and there is a commitment to continually engage using a variety of methods which includes regular updates to Clinical Commissioning Group Patient Assurance Groups.

In Spring 2015, 'Joined Up Leeds' was developed as a two week period of conversations taking place across the city. Citizens discussed how their health and wellbeing data could and should be shared, the benefits of sharing, the concerns they have, and how information could be used for the benefit of people in Leeds. The recommendations from the report resulted in creating a leaflet called "Sharing Healthcare Records" that was co-produced with patients and distributed across the city via GP Practices.

Following on from the success of Joined Up Leeds, 'Joined Up Leeds 2' gathered the views of local people to find out whether citizens of Leeds want a Personal Health Record, how they would use it and how it might affect their health and the relationship they have with their healthcare providers. The results of the engagement have been published widely since the report was finalised in Spring 2016.

From the outset, Leeds Care Record has engaged with patients, stakeholders and service users. Regular meetings are held with a dedicated patient group who have helped to develop the communications material, wider reaching patient engagement and the communication plan. The project team also meet many of the patient representative groups for GP Practices to inform them of the project. For specific areas of development, the team have commissioned a third sector organisation to engage with patients and service users to help inform the project. A number of methods have been used: surveys, face to face interviews, focus groups and piggybacking network events. An extensive engagement exercise was delivered to ensure we understood the requirements of people regarding what aspects of their mental health information should be shared by asking the views of services users first. The results were then used by clinicians to identify the data that was relevant to share.

Further communication with citizens is also conducted using a multi-platform approach of online presence, social media, local press, posters and leaflets to promote the work to a wide audience in the city by using a combination of channels.

Leeds has also run a number of engagement sessions with patients and the voluntary sector as its role as a pathfinder for the care.data programme and the National Data Guardian review and will continue to do so.

Information sharing

Information governance is very strong within acute care, mental health and social care exceeding the national average. Community Health is less mature at a strategic level, however good training is provided to professionals on day to day information management.

Above organisation level Leeds has a city-wide Information Governance Committee, jointly chaired by senior officers in health and social care.

A common Information Sharing Agreement with all the major providers within Leeds Health and Social Care was agreed in 2014 and reviewed again in 2015 to account for changes in legislation with the introduction of the Health and Social Care (Safety and Quality Act 2015).

All health organisations and the Local Authority in Leeds are compliant with the IG Toolkit to Level 2 and above verified by an annual rolling program of internal audit assurance. The IG Toolkit addresses areas such as business continuity plans. As individual Data Controllers each organisation takes responsibility for their policies, plans and procedures. Leeds Local Authority and health providers have thus have robust policies and procedures in place for all the areas identified.

All NHS organisations use the NHS number as the primary identifier for a patient. Patient Administration Systems and Electronic Patient Record systems that manage the Patient Master Index (PMI) either use or moving towards PDS to match NHS numbers dynamically.

In terms of new regulations, all organisations will be implementing the Accessible Information Standards and are working with their suppliers to adapt information systems accordingly.

Most organisations have adequate arrangements in place for assessing the clinical safety aspects of implementing new or adapting information systems.

Data quality is recognised as essential and underpinning to the use of digital systems to replace paper. Organisations have arrangements in place to improve data quality.

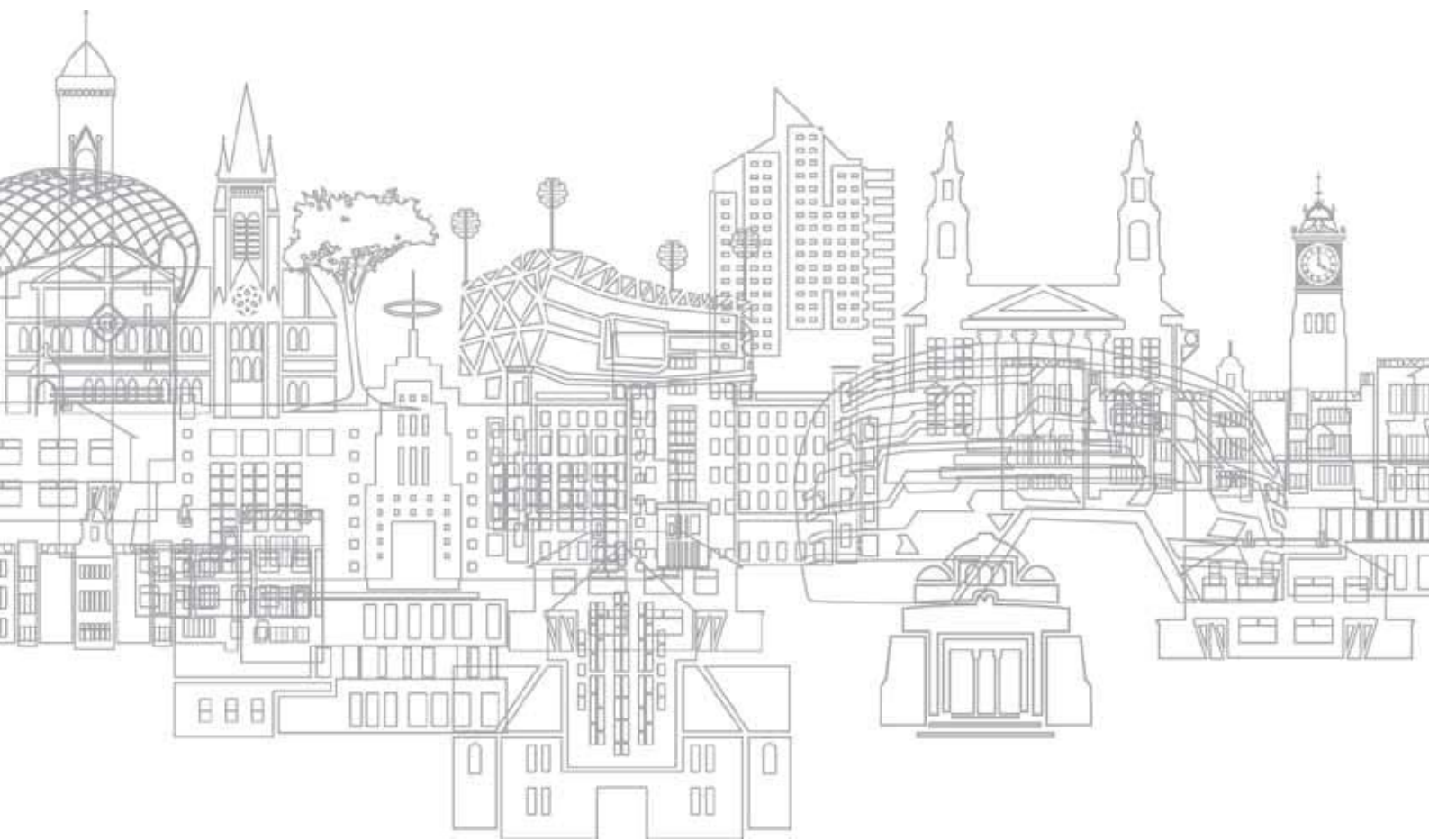
Other strategic stakeholders

Healthy Futures: A West Yorkshire Sustainability and Transformation plan is being developed to cover 11 CCGs and the health and care providers therein.

The approach is to bring together local place based plans and collaborative West Yorkshire plans to deliver the required cumulative impact and the right interventions and services at a population level to meet the identified gaps. Whilst local plans retain primacy as much of the transformation will be delivered at this local level, there are some gaps and challenges where the work needs to be undertaken at a West Yorkshire level. Three key questions will be used to determine where value can be added at a West Yorkshire level using the 'West Yorkshire Lens'. Based on this approach, six priority areas have been identified which will form West Yorkshire workstreams to deliver the change required. These are:

- Cancer
- Urgent and Emergency Care (including the Urgent and Emergency Care Vanguard)
- Specialised Commissioning
- Mental Health
- Prevention at Scale
- Hyper-acute stroke

These workstreams and local plans are supported by a number of enabling workstreams including digital and interoperability, workforce and OD, communications and engagement. Leeds is taking a lead technology role in the digital enabling work and particularly the Urgent and Emergency Care Vanguard.



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The Leeds Local Digital Roadmap has the following supporting documents:

- Universal Capability Delivery Plan
- Capability Deployment Schedule
- Capability Trajectory (Secondary Care)
- Information Sharing Approach

The main contributing organisations have been as follows:

- NHS Leeds North Clinical Commissioning Group
- NHS Leeds West Clinical Commissioning Group
- NHS Leeds South and East Clinical Commissioning Group
- Leeds City Council
 - Adult Social Care
 - Children's Services
 - Public Health
- Leeds Teaching Hospitals NHS Trust
- Leeds Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- General Practice
- Informatics leads from West Yorkshire Clinical Commissioning Groups
- West Yorkshire Urgent and Emergency Care Network/Vanguard
- Leeds Third Sector organisations

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