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HEALTH AND WELLBEING BOARD

Meeting to be held in Room 412, Rose Bowl,
Leeds Beckett University, Portland Crescent, Leeds, LS1 3HB on
Tuesday, 6th September, 2016 at 1.30 pm

There will be a pre-meeting for Members of the Board at 1.00 pm

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MEMBERSHIP

Councillors
R Charlwood (Chair)
D Coupar
L Mulherin
S Golton
G Latty

Representatives of Clinical Commissioning Groups

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

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

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative
Kerry Jackson – St Gemma's Hospice

Representative of Local Health Watch Organisation
Lesley Sterling-Baxter – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

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

Agenda compiled by:
Governance Services – 0113 2474355

A G E N D A

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

Item				Page
4			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
5			**DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
6			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
7			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
8			**MINUTES** To approve the minutes of the meeting held 21st April 2016 as a correct record.	1 - 10
9			**LEEDS HEALTH AND WELLBEING BOARD WORK PLAN 2016/17** To consider the report of the Chief Officer, Health Partnerships, seeking approval for the Health and Wellbeing Board work plan for 2016/17 and the approach to keeping the work plan live. (Report attached) (Appendix 1 to follow)	11 - 14

10			**TOWARDS BETTER JOINT HEALTH AND CARE WORKING - A GOVERNANCE UPDATE** To consider the report of the Chief Officer, Health Partnerships, on the current health and care partnerships for Leeds and West Yorkshire and explores the relationships between the 'top tier' structures and the Health and Wellbeing Board. In order to deliver the ambition for Leeds to be the Best City for Health and Wellbeing, the Leeds Health and Wellbeing Board must be assured that the right health and care partnership structures are in place and that they allow the Board influence across the partnerships.	15 - 28
11			**SUSTAINABILITY TRANSFORMATION PLANS (STPS)** To consider two reports relating to the Sustainability and Transformation Plans and to undertake a joint discussion of both. **1) Update on Development of the Leeds Sustainability and Transformation Plan (STP)** To consider and discuss the report of the Chief Operating Officer, NHS Leeds South and East CCG which provides an overview of the STP development in Leeds and West Yorkshire. **2) Local Digital Roadmap (LDR)** To consider and discuss the report of the Clinical Chair and GP, NHS Leeds North CCG, providing assurances that the LDR takes appropriate account of the Leeds Health and Wellbeing Strategy 2016-2021, the Leeds STP and will contribute to the delivery of the digital infrastructure capability required to meet the needs of the health and care system in the future	29 - 84

12			**FOR INFORMATION - LEEDS BETTER CARE (BCF) UPDATE** To note the joint report of the Chief Operating Officer, NHS Leeds South and East CCG and the Director of Adult Social Services, Leeds City Council which provides the Board with an update on the final version of the BCF Narrative Plan for 2016/17 and the BCF Quarter 4 return for 2015/16.	85 - 194
13			**ANY OTHER BUSINESS**	
14			**DATE AND TIME OF NEXT MEETING** To note the date and time of the next meeting as Thursday 20th October 2016 at 9.30 am	

Third Party Recording

Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda.

Use of Recordings by Third Parties– code of practice

a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.
b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.

HEALTH AND WELLBEING BOARD

THURSDAY, 21ST APRIL, 2016

PRESENT: Councillor L Mulherin in the Chair

Councillors N Buckley, D Coupar, and L Yeadon

Representatives of Clinical Commissioning Groups

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

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adult Social Services

Representative of NHS (England)
Brian Hughes - NHS England

Third Sector Representative
Heather O'Donnell – Age UK Leeds

Representative of Local Health Watch Organisation
Lesley Sterling-Baxter – Healthwatch Leeds

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

70 Chair's Opening Remarks

The Chair welcomed all present to the last meeting of the Health and Wellbeing Board (HWB) for the 2015/16 Municipal Year and thanked all Board members for the work they had undertaken during the previous, challenging year.

The Chair also took the opportunity to introduce a brief animated film promoting the refreshed Leeds Health and Wellbeing Strategy. Board Members and partners were encouraged to utilise the film in their own organisations to promote the Strategy as widely as possible.

Councillor Mulherin additionally welcomed Lesley Sterling-Baxter to her first meeting as representative of Leeds Healthwatch. It was noted that Lesley and John Beale had been appointed as Co-Chairs of Leeds Healthwatch after Linn Phipps stood down from the position of Chair. Councillor Mulherin expressed her thanks and best wishes to Linn on behalf of the HWB. It was agreed that the Chair would write to Linn to formally acknowledge her contribution to the

work of the Board and the development of the Leeds Health and Wellbeing Strategy.

71 Appeals against refusal of inspection of documents
No appeals against refusal of inspection of documents were received.

72 Exempt Information - Possible Exclusion of the Press and Public
No exempt information was contained within the agenda.

73 Late Items
No formal late items of business were added to the agenda, however the following supplementary documents were despatched prior to the meeting:
Item 8 – Leeds Health and Wellbeing Strategy – Appendix 2 to the report (minute 78 refers)
Item 9 – CCG Operational Plans 2016-17 – Appendices A, B and C to the report (minute 79 refers)
Item 12 – Leeds Better Care Fund – Appendix A of the report (minute 82 refers)

74 Declarations of Disclosable Pecuniary Interests
No declarations of disclosable pecuniary interests were made.

75 Apologies for Absence
Apologies for absence were received from Councillor Golton, Gordon Sinclair (Leeds CCG) and Moira Dumma (NHS England). The Chair welcomed Brian Hughes as representative for NHS England.

76 Open Forum
The Chair allowed a period of up to 10 minutes for members of the public to make representation on matters within the remit of the Health and Wellbeing Board (HWB)
Refugee and Asylum Seeker access to Healthcare – Lorna Gledhill, Regional Asylum Activism Co-ordinator for Yorkshire & Humberside, addressed the meeting on tackling existing barriers to healthcare faced by refugees and asylum seekers in relation to the recent Department of Health Consultation, 'Making a Fair Contribution'. Specifically, concerns about the impact of the proposed changes outlined in Consultation on entitlement to free NHS care in England for refugees and people seeking asylum.

Ms Gledhill highlighted the complex medical needs, mental health support and maternal health needs refugees and asylum seekers often required whilst awaiting the outcome of their request to stay and the challenges they faced when accessing healthcare, particularly GP healthcare.

Ms Gledhill acknowledged the response to the Consultation sent by Leeds City Council and urged individual Board members to raise concerns again directly with the Department of Health over the impact of charging for healthcare on the refugee and asylum seeker groups as well as the wider population. Additionally, the Board was encouraged to consider the refugee and asylum seeker population during discussions on the refreshed Leeds

Health and Wellbeing Strategy. The Board noted the response that migrant health remained a priority for the Leeds Health Protection Board

RESOLVED –

a) To note the contents of the representation and the comments made during discussions
b) To note that a copy of the response submitted by Regional Asylum Activism to the 'Making a Fair Contribution' consultation would be shared directly with individual Board members

77 Minutes

RESOLVED – To approve the minutes of the meeting held 20th January 2016 as a correct record

78 Leeds Health and Wellbeing Strategy

The Board considered the joint report of the Director of Adult Social Services, The Director of Public Health and the Director of Children's Services which accompanied the publication of the Leeds Health and Wellbeing Strategy 2016-2021. The report provided a summary of findings from the public engagement undertaken and of the changes subsequently made for the final publication since the last report to the Board on 20th January 2016.

Appendix 1 of the report provided a summary of the third phase of engagement undertaken on the strategy. A copy of Appendix 2 - the final Leeds Health and Wellbeing Strategy 2016-21 document - was provided as a supplement following the despatch of the agenda. At the meeting, the Board received a copy of Appendix 3 – indicator wording and technical descriptions.

Paul Bollom, Chief Officer, Health Partnerships, presented the refreshed Strategy 2016/21 and highlighted the benefits for all Board partners being able to use the longer term strategy effectively to promote and improve health outcomes in Leeds.

During discussions the following comments were made:

- The Strategy was an "all age" strategy, from birth through to end of life care
- The Strategy had been effective in helping to inform the emerging Sustainability and Transformation Plan (STP) for Leeds. The next iteration of the STP would better reflect and link to the approach of the newly signed-off Strategy
- Whether the design and graphics used in the Strategy could be utilised in other health Plans/Strategies to further emphasise and reinforce the joined-up partnership working. The Board also suggested that the graphics and design for the Sustainability and Transformation plan should be consistent with the Leeds Health and Wellbeing Strategy wherever possible.

The Board welcomed the Leeds Health and Wellbeing Strategy and expressed thanks to the team who had produced the document.

Arrangements for the launch of the Strategy were briefly discussed, noting that details would be sent to Board members shortly.
RESOLVED - That the Leeds Health and Wellbeing Strategy 2016-2021 be approved.

79 Clinical Commissioning Group Operational Plans 2016-17

Further to minute 61 of the meeting held 20th January 2016, where the Board considered the NHS planning guidance and cost pressures facing the three Leeds CCGs in 2016-17, Matt Ward, Chief Operating Officer, Leeds South & East CCG, presented a report providing a high level overview of the three Leeds CCG's 1-year Operational Plans for 16-17. The report included information on the city-wide commissioning plans as well as the individual CCG plans included within Appendices A, B & C which were despatched as part of a supplementary pack prior to the meeting.

The report outlined the new planning requirements introduced for NHS in 2015 - the production of a 1-year operational plan (per NHS organisation); and the creation of a place-based 5-year Sustainability and Transformation Plan (STP).

The individual Operational Plans provided details of the CCGs forward planning aimed directly at meeting local needs. The presentation set the context of the Plans within the hierarchy of the Leeds Health and Wellbeing Strategy and the Sustainability and Transformation Plan; emphasising the links to those two documents.

The Board noted that this year the Plans placed additional focus on:
- Value, particularly in primary and community care
- New models of care and new models of testing
- Support and system resilience
- How the 2016-17 CCG plans would support a sustainable Health and Social Care System
- Improving the health of the most disadvantaged the fastest, through focussed and targeted commissioning

During discussions, comments on the responsiveness of the Operational Plans to workforce and resource pressures were noted. The Board also noted that all plans refer to and address the same pressures, both in primary care and hospital settings.
RESOLVED –
a) To note the comments made during discussions on the development of the CCG operational plans in the context of the place-based five-year Sustainability and Transformation Plan (STP).
b) That having considered the CCG Operational Plans, the Board considered that the Plans did take proper account of the Leeds Health and Wellbeing Strategy 2016-2021.

80 Update on NHS England Commissioning Plans and Intentions for 2016-17

Brian Hughes, Locality Director, NHS England (NHSE) presented a report which set out the NHSE Commissioning Plans and intentions for 2016-17. The report highlighted how the Plan aligned with the NHSE assurance role and direct commissioning responsibilities; as well as reflecting both national and West Yorkshire service requirements.

Additionally the Plan considered the following:

- The focus of Primary Care, not just GP care, as well
- The issues around dental care and the challenges ahead particularly emergency access to dental care
- The aim to align with the focus of Public Health responsibilities
- Ongoing work in respect of specialised service areas

Discussions followed during which the following comments were noted:

- The focus on dental health was welcomed, noting the current pressure on the 18 week treatment wait and that the largest Dental Hospital was based in Leeds. The issue of dental health was flagged as a future focus for the HWB
- Noted that, due to pressure on District Hospitals and their lack of capacity, more cases presented to Leeds Hospitals generally and the NHSE Plan was welcomed in terms of its aim to plan for such instances. The response was noted that the Plan promoted collaborative working in such instances – where treatment is undertaken in Leeds and subsequent recuperation is provided by District Hospitals
- Workforce pressures and the impact that the reported lack of qualified nurses had on the ability to provide general, primary and elderly care. Additionally the effect of the diminishing number of GPs was noted
- Workforce pressures in relation to the gaps in services. The Board noted the comment that a mapping exercise of workforce provision and availability should be a key feature of the STP and be undertaken prior to the design of future services
- General Practice provision and accommodation in Leeds, and whether there were funds available to improve premises. The Board noted the response that funds were available as part of the CCGs devolved responsibilities. NHSE worked closely with the three Leeds CCGs to plan to minimise the impact of GP retirement or premises closures.

In response to a query regarding the consultation on Children's Epilepsy Services, it was noted that the process of consultation on proposals for 4 national centres was ongoing. The Chair received the support of the Board to write to the Department of Health to urge consideration of a 5th Yorkshire and Humber Centre to support the 9 million residents of the region.

The Board considered both the CCG Operational Plans and the NHS England Plan together. In conclusion, the Plans were welcomed by the Board, particularly their presentation together with the Leeds Health and Wellbeing Strategy which clearly emphasised the links and consistency between the documents.

RESOLVED - That the comments made during discussions on the development of NHS England's Commissioning plans and intentions for 2016-17 be noted

81 Sustainability and Transformation Plan Update

Matt Ward, Chief Operating Officer, Leeds South and East CCG, presented a report which provided the Board with an overview of the development of the Sustainability and Transformation Plan (STP), including the relationship between the Leeds STP and the West Yorkshire STP.

The report sought support for the approach undertaken to develop the Leeds STP as well as the key areas to be developed April to June 2016. The priorities, ambitions and technical detail on how the outcomes will support the Leeds Health and Wellbeing Strategy were highlighted along with the following matters:

- The focus of the West Yorkshire STP on urgent and emergency care, cancer, mental health and specialised services
- Funding and resource commitments were considered to better understand how individual health care providers could work together in partnership
- The emphasis on an enhanced social contract; prevention and rapid response in a time of crisis; efficient and effective secondary care; innovation, education and research
- The development of a consultation plan

It was also noted that key points from the Health and Wellbeing Board workshop held on 17th March 2016 had informed and shaped the STP.

During discussions, the Board made the following comments:

- Acknowledged that it was crucial to encourage individual organisations to work together and have regard to all partners to ensure delivery of services in the light of the financial constraints
- Support was expressed for the key themes of the STP
- How the Leeds STP integrated with the wider West Yorkshire STP was seen as a key issue
- Recognition for the work undertaken to establish public consultation on the Plan and the comments made in respect of providing the public with unambiguous information on resources and what they can expect from a diminished public purse
- Recognition of the role that Leeds Healthwatch will play in the consultation/engagement process
- Recognised that the role of the members of the Third Sector as a key partner organisations and solution providers should be emphasised within the STP. The recent establishment of the Third Sector Forum was noted and Heather O'Donnell, Third Sector representative, extended an offer to work on the further development of the STP.

In conclusion, the Board welcomed the links and integration between the developing STP and the Leeds Health and Wellbeing Strategy. The Board

also expressed thanks to the team developing the STP for the volume of work undertaken already, particularly recognising the work done to reflect the Board's desire expressed at the January 2016 meeting to create a Leeds specific STP.

RESOLVED -

a) That the approach described within this paper for the development of the STP be endorsed by the Board;
b) That approval be given to the key areas of focus identified in this report as the ones that the Leeds STP will focus on and will support the delivery of the Leeds Health and Wellbeing Strategy;
c) That support be given by the Board to ensure that staff and resources from the organisations represented by the Board are made available to support the development and implementation of the STP;
d) To note that the draft STP will be made available for review and comment by the Health and Wellbeing Board in June 2016 prior to its submission to NHS England on 30 June 2016.

82 Leeds Better Care Fund Plan 2016-17

Matt Ward, Chief Operating Officer, Leeds South and East CCG, presented a report as an introduction to the Better Care Fund (BCF) Submission, which required sign-off from the Health & Wellbeing Board prior to its final submission. It was noted that the date for submissions had changed since the publication of the agenda from 25th April 2016 to 3rd May 2015. As this was the second operational year of the BCF; the report provided a comparison between 2015/16 and 2016/17 and noted that the general ambitions remained constant.

The report detailed how, although the BCF allocation for 2016/17 was £1 million more than last year (a total of £55.9 million), in real terms this amounted to a reduction due to the level of contingency funds that will be needed to ensure stability in the system (in order to counteract any potential further increases in non-elective admissions to hospital), as well as the national withdrawal of the Social Care Capital Grant and the ring fence around the use of the Disabled Facilities Grant.

In response, the contingency fund had been capped at £7.5 million. Any funds not used to buffer non-elective admission activity in-year will be re-directed to supporting out of hospital services. Additionally, schemes that had not met their 'invest to save' targets would not receive BCF funding in 2016-17. Schemes in receipt of BCF support in 2016-17 would form part of the whole system response to health and social care transformation and be monitored accordingly.

The significant impact of non-elective admissions on the future BCF plan was acknowledged; and would be a main theme of the focus of the BCF Delivery Group & Partnership Board during 2016-17. Additionally, the report outlined a proposal for the BCF Delivery Group/Partnership Board to engage both the Clinical Senate and Leeds Institute for Quality Healthcare (LIQH) for appropriate analysis and advice from a practice perspective to support the aim to reduce the level and cost of avoidable non-Elective Admissions.

Steve Hume and Cath Roff, LCC Adult Social Services, further emphasised the impact of both non-elective admissions and the delayed transfer of care on the fragility of the system and the overall impact of funding changes, including tariffs and the 'invest to save' funds.

Discussion followed on the impact of mid-year restricted funding which occurred during 2015/16 on the delivery of some schemes. Comments were noted on how the subsequent gaps in service provision were met with responsive stand-alone schemes and that the various responsive pathways into care now required review as better integration was required to plan for such instances. Additionally the need to ensure all schemes proposed to the BCF met all of the BCF criteria was emphasised. The Board also acknowledged the real tension between the requirements of the BCF, national evidence and actual knowledge of the local services.

Members also noted comments made that whilst discussing the 2016/17 BCF, the Board had also just considered the Leeds Health and Wellbeing Strategy and the STP, both of which are 5 year plans. In light of this and the changing national requirements, the Board noted the importance of system leaders 'holding their nerve' in order to deliver on the longer term strategic outcomes of the city.

(Councillor Yeadon joined the meeting at this point and requested that her support as Executive Member for Children and Families for the Leeds Health and Wellbeing Strategy be formally recorded. Additionally, Councillor Yeadon reported the support of Children's Services for the Strategy and gave apologies for Nigel Richardson (Director of Children's Services) who was attending a meeting of Scrutiny Board (Children's Services)

RESOLVED

a) To note the priorities and commitments described in the Plan.
b) That, having considered the BCF Plan, approval be given to the Plan prior to final submission on the 3rd May 2016.
c) That the proposal to engage the Clinical Senate and Leeds Institute for Quality Healthcare (LIQH) in reviewing the level of Non-Elective Admissions from a practice perspective be endorsed

83 For Information: Delivering the Strategy

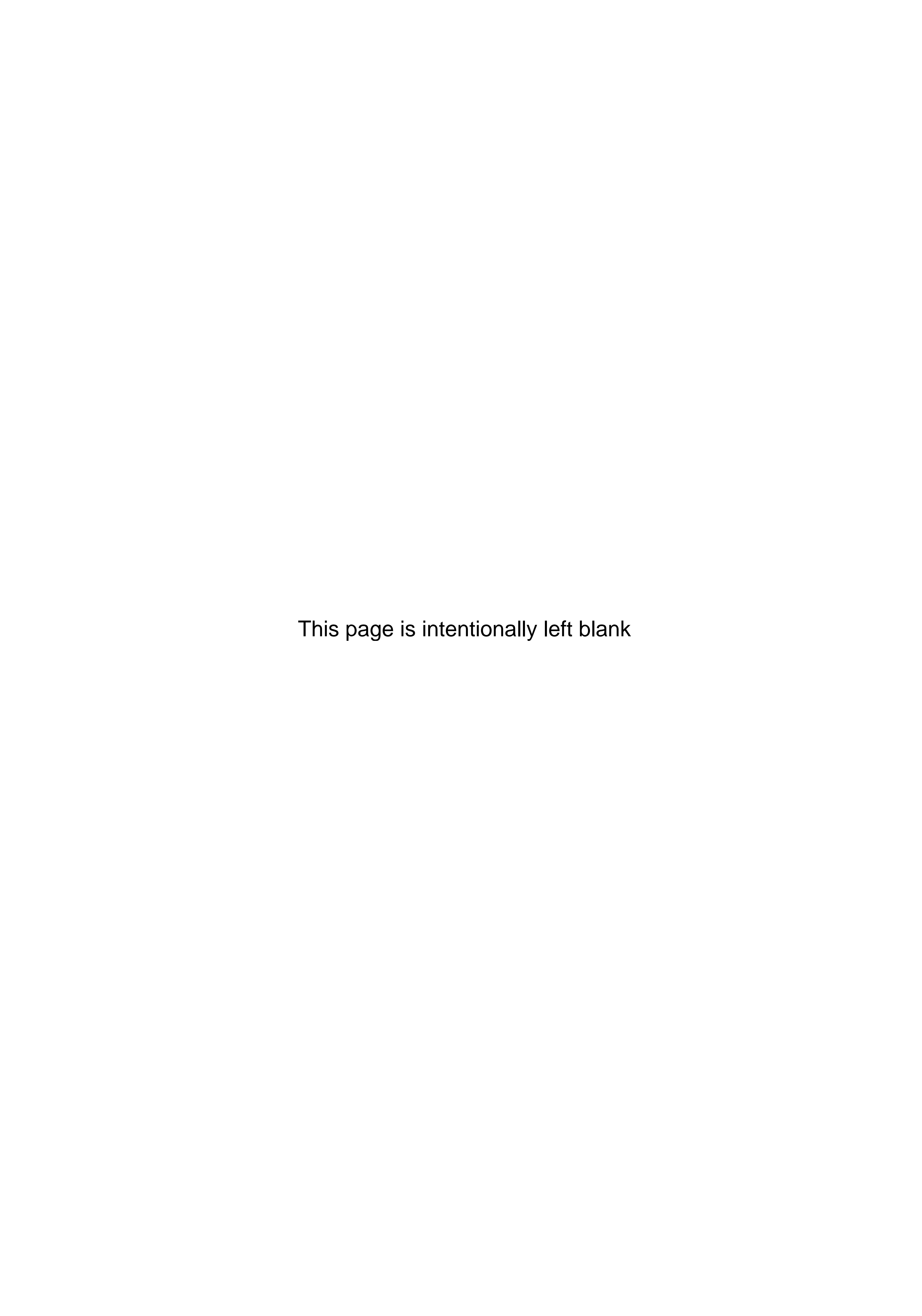
The Board received a copy of the bi-monthly "Delivering the Strategy" document, which gives the Board the opportunity to monitor progress of the Joint Health and Wellbeing Strategy 2013-15.

In response to comments regarding the appropriateness of the current performance indicators, the Board noted that national data sets and indicators had changed through the course of the year. Further work would be done with the Board and performance leads across the city throughout the summer to agree the best way to monitor the progress of the refreshed Strategy.

RESOLVED – To note receipt of the "Delivering the Strategy" Joint Health and Wellbeing Strategy monitoring report

84 Any Other Business

Future meeting dates – Arrangements for a Board meeting on June 2016 would be confirmed with Board Members in due course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Leeds Health & Wellbeing Board

Report author: Holly Dannhauser,
Health Partnerships Team

Report of: Paul Bollom (Chief Officer, Health Partnerships)

Report to: The Leeds Health and Wellbeing Board

Date: 06 September 2016

Subject: Health and Wellbeing Board work plan 16/17

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

Summary of main issues
In April 2016, the Leeds Health and Wellbeing Board (HWB) agreed that a forward plan for 2016/17 be developed during summer 2016 to reflect the priorities of the Leeds Health and Wellbeing Strategy 2016-21 and the Sustainability and Transformation Plans. The development of a work plan for the Board aims to help maintain a focus on strategic priorities, enable the full participation of board members, increase public engagement and support the Board's move from talk to action.

Recommendations
The Health and Wellbeing Board is asked to:
- Approve the Health and Wellbeing Board work plan for 16/17
- Approve the approach to keeping the work plan live

1 Purpose of this report

This report accompanies the 2016/17 work plan for the Health and Wellbeing Board, which is attached at appendix 1. It provides a summary of the process taken to develop the work plan and sets out an approach for regularly reviewing and updating the work plan. It has been driven by the priorities of the Leeds Health and Wellbeing Strategy, with sessions supporting the Board's relentless focus on reducing health inequalities, creating a high quality health and care system and having a financially sustainable health and care system.

2 Background information

At the formal meeting of the Leeds Health and Wellbeing Board in April 2016, it was agreed that a forward plan for 2016/17 will be developed during summer 2016 to

reflect the priorities of the Leeds Health and Wellbeing Strategy 2016-21 and the Sustainability and Transformation Plans (STP).

Early in 2016, the Health and Wellbeing Board secured external leadership support through the Local Government Association (LGA). Support has been provided through a series of development workshops for Board members, with the aim of maturing relationships and ensuring the Board is best placed to discharge its duties, provide strategic direction and navigate the Leeds health and care system through the challenges ahead.

In the same time frame since April 2016, the Health and Wellbeing Board has also had a number of opportunities to learn more, inform and shape the development of the STP, with common themes and challenges captured in the work plan.

3 Main issues

3.1 Purpose of the work plan

LGA guidance states that 'the most effective HWBs lead a place-based approach to health and wellbeing, where all partners share a common understanding and vision, key priorities and resources for achieving these. It is imperative that the HWB is the place where senior leaders come together to develop this oversight.'[1]

The work plan for the Board aims to maintain a focus on the strategic priorities of the Leeds Health and Wellbeing Strategy 2016-21 and the STP to achieve a shared vision for Leeds. It aims to build a structure through which the Health and Wellbeing Board can strengthen its collective responsibility for the Leeds £, setting the strategic direction as if it were one organisation, and with a relentless focus on:

- Reducing health inequalities
- Creating a high quality health and care system
- Having a financially sustainable health and care system

Therefore, there is a common thread in the work plan, linking together governance, decision making and models of care. Sessions are themed and questions will be posed for the Board to answer to increase the level of challenge and collective action. This approach supports senior leaders to come together to have oversight and take action on the big issues facing Leeds.

The Board has a number of statutory duties set out in the Terms of Reference, which are also reflected in the content of the work plan to enable the Board to fulfil and build on its core functions.

3.2 Public engagement

In workshops and formal meetings, it is important that Board members get to hear the views and experiences of Leeds citizens and that people are involved in the work of the Board. This is part of the Leeds approach to working with people in Leeds.

[1] *Making an impact through good governance: A practical guide for Health and Wellbeing Boards,* Local Government Association (October 2014)

Service users and members of the public will be involved in ways appropriate to the format and content of the Health and Wellbeing Board session, but this may include changes to Board papers and templates, screening short films, inviting service users/citizens to attend for a section of the private or public session, visits to services/communities.

Venues in community rather than 'corporate' settings will be sought, preferably where there is a relevant link to the content of the session.

3.3 **Reviewing the work plan**

The work plan is live and will be reviewed throughout the year to allow the Board to respond to changing demands and decisions. Board members are asked to recommend future workshop topics pertinent for the priorities of the Leeds Health and Wellbeing Strategy 2016-21.

Agenda items for formal meetings should be recommended at a time which provides the Board the opportunity to shape and inform a project, plan or Strategy at its outset and also allows for the Board to be cited at its completion.

Board members and paper authors will be asked to regularly identify future challenges. These will be reviewed and appropriately fed into the ongoing work plan as areas of focus. An end of year analysis could also be conducted to review all identified challenges and for the Board to determine action around each issue and inform the work plan for the following year.

4 Health and Wellbeing Board Governance

4.1 **Consultation and Engagement**

During summer 2016, the Health and Wellbeing Board has received organisational development support from the LGA, delivered through a series of workshops. In these sessions, Board members have discussed and agreed areas of focus, priorities for action, and difficult conversations needed around common themes. The work plan is based on suggestions captured at these development workshops which have taken place throughout the summer.

A draft version of the work plan was shared with all Health and Wellbeing Board members and a workshop session was held for members on 28th July 2016 to review the work plan and seek feedback. Members who were unable to attend were offered a telephone call or meeting with a member of the Health Partnerships Team, providing an opportunity to inform the work plan.

Both the workshop and individual sessions with Board members have been positive, with constructive feedback shaping the details of the work plan.

4.2 **Equality and Diversity / Cohesion and Integration**

There are no direct equality and diversity implications from this report.

4.3 **Resources and value for money**

The work plan has been created within the context of the financial challenges facing Leeds, as set out in the Leeds Health and Wellbeing Strategy 2016-21 and the developing STP. The Health and Wellbeing Board has a relentless focus on having a financially sustainable health and care system, which is reflected in the development of the work plan.

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

There are no direct risk management implications arising from this report. Programmes relevant or mentioned in the work plan of the Health and Wellbeing Board will have their own risk management arrangements and the business of the Board will receive assurances that partners work collaboratively for mitigation and resolution of these risks.

5 Conclusions

A work plan is a tool which makes for a more effective Health and Wellbeing Board. This plan provides an important opportunity to embed the Leeds Health and Wellbeing Strategy 2016-2021 firmly at the centre of the Board's role. It will It will help turn the strategic priorities of the Strategy into action and constantly ask what it is that the HWB can do to add value and drive change around challenges and opportunities facing our health and care system and experienced by Leeds citizens.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Approve the Health and Wellbeing Board work plan for 16/17
- Approve the approach to keeping the work plan live

7 Appendices

Appendix 1: Draft Health and Wellbeing Board work plan 16/17 (this will be a late supplement to the Board)

Leeds Health & Wellbeing Board

Report author: Paul Bollom (Chief Officer, Health Partnerships Team), Lisa Gibson (Strategy and Development Manager, Health Partnerships Team) & Holly Dannhauser (Health Partnerships Manager, Health Partnerships Team)

Report of: Paul Bollom (Chief Officer, Health Partnerships)

Report to: The Leeds Health and Wellbeing Board

Date: 06 September 2016

Subject: Towards Better Joint Health and Care Working – A Governance Update

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

Summary of main issues

Health and Wellbeing Boards create the space for senior leaders to come together to develop strategic oversight and direction for health and care. In Leeds, the Board takes a place-based approach to tackling the priorities set out in the Leeds Health and Wellbeing Strategy 2016-21 and, through collective leadership around a shared vision, sets the direction for our city to reach its outcomes. This is in the context of a changing health and care system at local, regional and national level, continuing financial challenge, and enduring health inequalities.

Therefore, the Leeds Health and Wellbeing Board must be assured that the right partnership structures are in place and that they allow the Board influence across the partnership to help achieve our shared ambitions for Leeds.

This paper sets out the current health and care partnership for Leeds and West Yorkshire and explores the relationships between the 'top tier' structures and the Health and Wellbeing Board[1]. It also highlights where relationships could be strengthened or shifted in order to provide the transparent and effective governance needed to achieve the outcomes of the Leeds Health and Wellbeing Strategy 2016-21.

Recommendations

The Health and Wellbeing Board is asked to:

- Agree that the right partnership structures are in place and that they help to achieve our shared ambitions for Leeds
- Consider whether the partnership structures create a space in which significant things can happen between or outside of Health and Wellbeing Board meetings (in which the Board has influence)

[1] This has been informed by the recent Price Waterhouse Cooper (PWC) governance review

- Endorse the proposals set out in section 3 of this report
- Consider whether proposals around reference/engagement groups such as the Leeds Academic Health Partnership and Leeds Clinical Senate satisfy issues around clinical voice and leadership
- Request an update on the progress of the Leeds Academic Health Partnership and Leeds Clinical Senate at a future meeting of the Board
- Request a further update and options for governance at a future meeting of the Board

1 Purpose of this report

In light of a changing health and care system at local, regional and national level, a continuing financial challenge and enduring health inequalities, this paper poses two key questions:

- Is the Board assured that the right partnership structures are in place?
- And do they allow the Board influence across the partnership to help achieve our shared ambitions for Leeds?

In order to help the Board answer these questions, this report details the Leeds health and care partnership structure and explores: purpose, role and membership of 'top tier' boards/groups; how they interact; their relationship with the Health and Wellbeing Board, and where relationships could be strengthened or shifted in order to provide the transparent and effective governance needed to achieve the outcomes of the Leeds Health and Wellbeing Strategy 2016-21.

All partners in the Health and Wellbeing Board have individual organisational decision making structures. This paper acknowledges that formal decision making is embedded in these structures and no changes are proposed to these functions within this paper. Engagement with wider stakeholders, including Third Sector, Healthwatch and elected members will be undertaken as appropriate and in-line with agreed processes/frameworks for any specific agenda items.

2 Background information

The national policy direction of greater collaboration, coordination and integration of health and care aims to improve health and wellbeing, improve the quality of services and ensure financially sustainable provision. This requires greater close working between partners especially, but not limited to, local government and the NHS.

Leeds has a great track record of partnership working across health and care. Our ambition is for the Leeds health and care system to act as 'one workforce'. This requires strong leadership, the right culture, and effective governance to allow collaboration in order to ensure our 'one workforce' can make the differences needed so that everyone in Leeds experiences the five outcomes of the Health and Wellbeing Strategy. Working fully in partnership with the Third Sector, Healthwatch Leeds, academic colleagues, those in caring and volunteer roles, and citizens is crucial to make the most of our city wide assets. Focused action across the partnership, with measures of change to outcomes or efficiency, is needed.

A Shared Intelligence report published in March 2016 explored the notion of Health and Wellbeing Boards as a 'hub' and a 'fulcrum'. The hub refers to a board's ability to bring the right people together in order to have coherent conversations which lead to

decisions and action. Highly effective boards provide this hub function, but also act as a fulcrum around which things happen. These are boards that create a space in which significant things happen between or outside of meetings, in which the board has a pivotal influence. A key attribute of a well performing Health and Wellbeing Board is a shared understanding of how the Board fits with other structures[2].

Locally, a review of the health and care system governance was commissioned from the consultancy PWC in 2015. This review reflected on the complexity and embedded investment (and potential for efficiencies) in the number of partnership and meeting structures. This paper takes forward recommendations from this work in relation to the boards and structures in scope of this paper.

2.1 Good governance

The purpose of good governance in this paper relates to ensuring decisions are made and implemented effectively. The characteristics of good governance may be captured as transparency, accountability, lawfulness, decisions which are based on consensus, participatory, responsive, and supportive of equity and inclusion.

2.2 National context

The NHS Five Year Forward View (2014) sets out 'a clear direction' for a radical shift in the shape of healthcare towards enhanced community provision. It discusses the challenges facing the health and care system over the next 5 years, characterised by three 'gaps' which must be closed if the health and care system is to continue to meet the expectations of patients and the public in a sustainable way:

- the health and wellbeing gap
- the close the care and quality gap
- the finance and efficiency gap

Local authorities also face significant questions as to how they maintain and improve the wellbeing of the communities they represent in light of general reductions in funding from central government and their public health functions specifically. Demographic growth, both overall and in populations of high need, requires them to both prevent where possible needs arising and to sustainably manage services and resources where they do. To achieve this, they increasingly need to create close operational relationships and / or joint services. To ensure strong collaboration, it is also important that decision making across the partnership takes into account direction set and decisions made in the wider democratic structures and fora.

As previously noted to the Health and Wellbeing Board in January and April, NHS England has initiated a place-based health and care planning approach to closing the three gaps in the Forward View: Sustainability and Transformation Plans (STPs). This approach promotes local action and decision making in managing the significant pressures on demand led services across health and care. NHS England has mandated that Leeds is part of a West Yorkshire STP footprint; this requires consideration as to how local government and democratic accountability (as well as Third Sector and Healthwatch Leeds) support and challenge joint working within this footprint. Leeds has also developed a local STP which sits within the wider West Yorkshire plan.

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[2] *The force begins to awaken: A third review of the state of health and wellbeing boards*, Shared Intelligence (March 2016)

Alongside the STPs, NHS England charged local areas with developing Local Digital Roadmaps, setting out plans for achieving the goal of being paper-free at the point of care by 2020. This is on a Leeds footprint and underpins delivery of the local STP through effective use of informatics and technology as well as enhancing individual organisational informatics capacity.

The Forward View also sets out key themes which influence the need to further develop partnership governance and may continue to influence organisational thinking. These include: maximising benefits from health and care technology, research and innovation; developing new models of care which may raise new questions about how Leeds commissions and contracts for services. Additionally, other national areas of interest include: the current financial incentive framework and measures taken to manage overall NHS spend by NHS England ('control totals') are being re-evaluated; the growing consideration of placed-based inspection and regulation by bodies, such as NHS Improvement, and the recent policy direction towards regional devolution including health and social care, i.e. Devo Manc.

Some Core Cities in England are exploring alternatives to governance of local health and care including most notably the devolution initiative in Manchester (as mentioned above) and the use of external chairing of executive boards (Birmingham). These approaches reflect local desire to deepen local, joint conversations and working in health and wellbeing, but it is as yet unresolved if these approaches explicitly benefit communities.

2.3 **Local context**

Leeds has a number of key documents which set out plans to achieve our vision for health and care through reducing health inequalities, delivering person-centred services closer to home and making best use of resources. These need to be supported through effective governance in order to ensure successful implementation.

Leeds Health and Wellbeing Strategy 2016-21 provides a framework for the partnership ambitions of the city. The Strategy is owned by the Leeds Health and Wellbeing Board, but emphasises the people of Leeds are our city's greatest asset and enablers for change.

The Strategy and work of the Board encompasses all ages, including children and families. Significant improvement in local indicators of children's wellbeing has been supported by the effective Children and Families Trust Board arrangements and Children and Young People's Plan which remain a partner to the Board in considering the health and education of children and families. This paper recognises the opportunity to ensure that the health of children and families is considered throughout partnership arrangements.

Leeds' STP arrangements (detailed in a paper also going to the Board on 6th September) emphasise the importance of working closely with citizens, communities and Third Sector partners to take a strong preventative approach and create a healthier city. Implementing the STP will require, as a minimum, joint arrangements in the city for engaging and communicating with the public, remodelling services, implementing new technology and supporting the workforce change. This paper recommends a basis for these arrangements within the resources and value for

money section in this paper and suggests further consultation with the Board as proposals become clear.

There is consensus across the partnership that a strong clinical voice is a prerequisite to Leeds arrangements and therefore there is a need to consider how this is expressed currently and may be improved further.

Finally, there is support for taking forward the recommendations of the PWC review, several of which have influenced the contents of this paper.

3 Main issues

In light of the national and local contexts set out above, there are a number of issues that could be addressed through greater transparency, clarity and good governance in our partnership structures, including:

- Understanding the Health and Wellbeing Board's relationship with other groups across the partnership
- Being clearer about how the Health and Wellbeing Board can set the strategic direction for health and care across the partnership and seek assurance on progress towards shared ambitions
- Strengthening the clinical voice and embedding clinical leadership
- Meeting the financial challenge and spending the Leeds £ wisely
- Making the best use of our city assets and opportunities to drive innovation and harness the use of technology for improved health outcomes and economic growth
- Delivering the Sustainability and Transformation Plan

LGA guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change[3]. The Leeds Health and Wellbeing Board has a strong reputation for collaborative relationships combined with a focus on the Leeds £. With good governance, there is an increased opportunity for the Leeds Health and Wellbeing Board to be a highly effective board that is a 'hub and fulcrum' around which things happen.

A brief summary on partnership groups is set out below to help create a shared understanding of how the Board fits with these other structures in order to achieve our shared ambitions and accommodate some of the emerging issues outlined above.

[3] *Making and impact through good governance – a practical guide for Health and Wellbeing Boards,* Local Government Association (October 2014)

3.1 **Health and Wellbeing Board**

Leeds Health and Wellbeing Board

Role

Strategic place-based leadership to improve the health and wellbeing of people in Leeds. Operating as one organisation around a shared vision, as set out in the Leeds Health and Wellbeing Strategy 2016-21, and spending the Leeds £ wisely to drive change across the local health and care system. The Board has a relentless focus on reducing health inequalities and creating a high quality and sustainable health and care system to help achieve our shared ambitions. This is achieved by using all resources of the Board from the statutory commissioning and delivery of services by Board members through to the broadest partnership influence on the wider determinants of health outcomes. The role includes statutory functions to assess population need in the locality through regular publication of a Joint Strategic Needs Assessment (JSNA) and an assessment of sufficiency of pharmacy provision in a locality through a pharmacy needs assessment (PNA).

Membership

The membership of the Health and Wellbeing Board is set out in statute in the Health and Social Care Act (2012). The Act provides a list of mandatory representatives to the board. There is local freedom to add to this membership and in Leeds this has been utilised to ensure that both CCG Chief Executives and Accountable Officers are represented as well as local NHS providers.

The current membership is:

- Executive Member for Health, Wellbeing and Adults, Leeds City Council (Chair)
- Executive Member for Communities, Leeds City Council
- Executive Member for Children and Families, Leeds City Council
- Elected Member, Conservative, Leeds City Council
- Elected Member, Liberal Democrat Group, Leeds City Council
- Chair, Healthwatch Leeds
- Chief Executive Officer, Healthwatch Leeds
- Third Sector Representative
- Clinical Chair, NHS Leeds North Clinical Commissioning Group
- Chief Accountable Officer, NHS Leeds North Clinical Commissioning Group
- Clinical Chair, NHS Leeds West Clinical Commissioning Group
- Chief Executive Officer, NHS Leeds West Clinical Commissioning Group
- Clinical Chief Accountable Officer, NHS Leeds South & East Clinical Commissioning Group
- Chief Operating Officer, NHS Leeds South & East Clinical Commissioning Group
- Director of Public Health, Leeds City Council
- Director of Adult Social Services, Leeds City Council
- Director of Children's Services, Leeds City Council
- Director of Commissioning Operations (Yorkshire and Humber), NHS England
- Chief Executive, Leeds and York Partnership NHS Foundation Trust
- Chief Executive, Leeds Teaching Hospitals NHS Trust
- Chief Executive, Leeds Community Healthcare NHS Trust

Proposals

1. The Board has a principle role in the oversight of the financial sustainability of the Leeds system
2. The HWB provide the strategic direction and leadership of the local STP
3. The HWB oversee the Partnership Executive Group (PEG), PEG as a meeting of the executive functions for the partnership in relation to the direct health and care system and therefore task it with implementing the Leeds STP
4. The HWB receive a quarterly report from the PEG, detailing progress on the STP. This will

include a quarterly financial health check for Leeds health and care provision, and a projection of progress in the implementing, commissioning and impact of the local STP

3.2 Leeds Health and Care Partnership Executive Group (PEG)

Leeds Health and Care Partnership Executive Group (PEG)

Role

PEG meets monthly and has agreed to work together in four ways:

- Work with people and families to enable them to take more control of their own health and care needs
- Provide high quality services in the right place, backed by excellent research, innovation and technology - including more support at home and in the community, harnessing the assets in the Third Sector, and using hospitals for specialised care
- Enable the health and care system to operate as if we were one organisation by removing barriers in order to make team working the norm across organisations and professional groups, as well as citizens, communities and Third Sector, so that people receive seamless integrated support
- Use the 'Leeds £', our money and other resources, wisely for the good of the people we serve in a way in which also balances the books for the city

PEG has proposed three tests as to judge its effectiveness: People are proactively supported to stay in their own home, family or community; People requiring hospital and residential nursing care will spend the minimum time possible there; the health and social care system in Leeds is financially sustainable.

Membership

The current membership is:

- Chief Executive Officer, Leeds City Council (Chair)
- Chief Accountable Officer, NHS Leeds North CCG
- Clinical Chief Accountable Officer, NHS Leeds South East CCG
- Chief Accountable Officer, NHS Leeds West CCG
- Chief Executive Officer, Leeds Community Healthcare NHS Trust
- Chief Executive Officer, Leeds Teaching Hospitals NHS Trust
- Chief Executive Officer, Leeds and York Partnership NHS Foundation Trust
- Director of Adult Social Care, Leeds City Council
- Director of Children's Services, Leeds City Council
- Director of Public Health, Leeds City Council
- Director of Commissioning Operations, Yorkshire and the Humber, NHS England
- Clinical representation appointed by the Clinical Care Senate
- GP/Primary Care Representative

Proposals

1. That PEG is tasked with providing the partnership of executives for the statutory health and care system
2. The Board ask PEG provide them with regular progress reports on the implementation of the Leeds component of the West Yorkshire STP and consider how wider West Yorkshire activity may support the city and wider locality. This is to be through a quarterly update to suit the boards meeting dates
3. That PEG should identify future challenges, changes and trends for consideration as part of the live work plan for the HWB
4. That PEG strengthen its accountability to the HWB through reporting of overall progress with

relevant aspects of the Leeds Health and Wellbeing Strategy as requested by the HWB
5. That PEG should recommend suitable partnership structures and arrangements to HWB enable it to fulfil its role as detailed above
6. That PEG consider where leadership or resources may be pooled, aligned or simplified to deliver the outcomes of the Health and Wellbeing Strategy

Relationship with Health and Wellbeing Board

The Health and Wellbeing Board determines the vision and outcomes for Leeds, assesses needs through a Joint Strategic Needs Assessment and sets direction through the Leeds Health and Wellbeing Strategy. PEG is tasked with putting this plan into action, working towards a health and care system which operates as one organisation. PEG is asked to provide a quarterly report to the Board and to identify future challenges and, where appropriate, suggest items for consideration as part of the HWB work plan in order for the Board to provide strategic direction.

3.3 Integrated Commissioning Executive (ICE)

Integrated Commissioning Executive (ICE)

Role

ICE provides a forum for local commissioners to act collectively to best utilise the 'Leeds £'. The role of ICE is to explore and negotiate opportunities for the joined-up commissioning of health and social care services in Leeds. By enabling joint working and unblocking system-wide barriers to integration, the ICE ensures the implementation of the Leeds Health and Wellbeing Board's long term strategy for the city and co-ordination of the partnership's commissioning actions to achieve the priorities in the Leeds Health and Wellbeing Strategy.

ICE currently has five functions:

- Supporting the delivery of the Leeds Health and Wellbeing Strategy 2016-21
- Developing an integrated commissioning strategy
- Integrating commissioning delivery
- Developing payments and incentive approaches
- Supporting innovation and enterprise

Membership

The current membership is:

- Chief Accountable Officer, NHS Leeds North CCG
- Clinical Chair, NHS Leeds North CCG (Co-Chair of ICE)
- Clinical Chief Accountable Officer, NHS Leeds South East CCG
- Associate Director of Commissioning, NHS Leeds South East CCG
- Chief Accountable Officer, NHS Leeds West CCG
- Clinical Chair, NHS Leeds West CCG
- Director of Adult Social Services, Leeds City Council (Co-Chair of ICE)
- Interim Chief Officer Commissioning, Adult Social Care, Leeds City Council
- Director of Children's Services, Leeds City Council
- Chief Officer Partnership Development and Business Support, Children's Services, Leeds City Council
- Director of Public Health, Leeds City Council
- Chief Officer Strategy and Commissioning, Public Health, Leeds City Council
- Director of Commissioning Operations, Yorkshire and the Humber, NHS England

Proposals

1. To note the current arrangements including membership and role of ICE to ensure they reflect the strategic role described
2. That at a future meeting, the HWB considers the work program of ICE in light of the Leeds

Health and Wellbeing Strategy and the commissioning implications of the Leeds and wider West Yorkshire STP

Relationship with Health and Wellbeing Board

The Board, through the Leeds Health and Wellbeing Strategy and the STP, provides the priorities for commissioning in the city. ICE supports the Board by providing the forum for strategic and operational commissioning of joint services.

3.4 Leeds Academic Health Partnership

Leeds Academic Health Partnership (LAHP)

Role

The LAHP brings together the strategic and operational health and care services alongside the city's universities and broader academic assets. The role of LAHP is to improve the health and wellbeing of the people of Leeds and reduce health inequalities by engaging the educational and research capabilities of all three universities in Leeds with the health and social care system in order to speed up the adoption of research and innovation, creating inward investment, and raising the national and international profile and reputation of the city.

LAHP has a particular focus on joint activity for health outcomes through the development of a health and care academy bringing together workforce development (including skills and supply), personalised medicine, and innovation through active research on population health. The focus on the practical impact of research (and to some extent workforce development) means that the LAHP will both work with the current operational priorities with a future view of technological horizons often spanning one to two decades ahead.

Membership

The membership of LAHP comprises the three NHS provider trusts working in Leeds, the three Leeds CCGs, the three Leeds universities and the local authority. LAHP may support other full or associate member organisations based on requests received and alignment to the Board's purpose.

The Board of LHAP therefore comprises:

- Vice Chancellor of the University of Leeds (Chair)
- Chief Executives of local NHS providers
- Chief Executive of Leeds City Council
- Accountable Officers and Clinical Chairs of Leeds CCGs
- Chair of the Clinical Senate
- Representative from Yorkshire Academic Science Network (YASN)
- Representatives from the University of Leeds
- Representative from Leeds Beckett University
- Representative from Leeds Trinity University

There is extensive overlap between the membership of this board and PEG to allow for effective alignment of purpose and progress.

Proposals

1. To provide an update on the progress of the LAHP to a future meeting of the Health and Wellbeing Board

Relationship with Health and Wellbeing Board

Through the Health and Wellbeing Strategy, the Board identifies priorities for the LAHP which it supports the Board with implementing. The LAHP has a particular role in taking forward priorities

within the LHWS for a strong economy with quality local jobs (priority 5), maximising the benefits of technology (priority 7) and a valued, well trained and supported workforce (priority 11).

3.5 The Leeds Clinical Senate (LCS)

Leeds Clinical Senate (LCS)

Role

The LCS aims to bring together senior health and care professionals across Leeds, irrespective of organisational boundaries, to take a system view of the issues and challenges faced. The LCS will support the Leeds health and social care system to make the best decisions about healthcare for our citizens by providing clinical leadership and guidance. To do this, the LCS will have three major functions:

- Reactive problem-solving: contributing to solving system-wide issues, concerns and problems brought to its attention by the HWB and the PEG by bringing together combined clinical intelligence and using academic research evidence and data
- Proactive horizon-scanning: looking ahead, with the aim of identifying research, innovation and developments which can contribute to solving the current and future challenges facing the health and social care sector and bringing these to the attention of the HWB and the PEG
- Leadership development: acting as a hub for clinical leadership development and communication across the system, overseeing the development of the Leeds Institute for Quality Healthcare, and supporting employers in their responsibilities to ensure a pipeline of future clinical leaders and clinical academics

Membership

In recognition of the LCS' functional responsibilities, the aim will be to include members from across a range a clinical professions; primarily but not exclusively medicine, nursing and social care colleagues. Members will have sufficient seniority and experience to contribute meaningfully to the LCS' functions and influence the system. Additional members will be invited depending on the work that is to be undertaken. In the first instance, it is proposed that the membership should be drawn from the three CCGs, the three NHS provider organisations and LCC. It should also include membership from the three Universities. This proposal is to be confirmed through discussions at a future LAHP Board meeting.

Proposals

1. LAHP has agreed that the Leeds Clinical Senate should come under its 'umbrella', which will provide it with administrative support.
2. The LCS would be developed to allow it to become a clinical reference/advisory group for the Leeds health and social care system (which may involve reviewing membership and structure)
3. That LAHP support the LCS to fulfil the above functions using PEG membership as a way to communicate, respond and help lead clinical conversations
4. That the HWB is provided with an update on the working and effectiveness of the LCS as part of the report on progress of the LAHP

Relationship with Health and Wellbeing Board

The Health and Wellbeing Board through the JHWS and STP provides the context for the clinical leadership provided by LCS, The Chair of the LCS as a member of PEG supports and informs the Board through this meeting.

3.6 **West Yorkshire Relationships**

There is a history of joint working at West Yorkshire (WY) level on specific areas, e.g. the Emergency and Urgent Care Vanguard, the 10 CC group and the West Yorkshire Alliance of Acute Trusts. Additionally, Leeds played a key role in bringing together senior health and care leaders from across West Yorkshire in early 2015 to explore opportunities to develop relationships and explore potential to work more closely together through the Collaboration of Chief Executives and the Health and Wellbeing Board Chairs group.

The West Yorkshire STP planning footprint chosen by NHS England (which initially could be viewed as challenging given the number of large organisations it involved) has provided a further opportunity to consider how West Yorkshire's NHS bodies and local authorities work together to tackle the three gaps. Senior colleagues from Leeds have taken on key roles in developing workstreams of the West Yorkshire STP. There is a recognition that delivering the West Yorkshire STP, particularly around sustainable quality secondary care and creating prevention 'at scale', will (only) be achieved with the support of quality conversations and effective governance. Rob Webster, Chief Executive of South West Yorkshire Partnership NHS Foundation Trust and Senior Responsible Officer for the West Yorkshire STP, is working with local areas to develop the structure to support this, including an officer-led steering group and wider reference group. It is likely that the HWB Chairs group will also have an oversight role. The update paper in relation to the Leeds STP at this board meeting includes more details of these West Yorkshire arrangements.

It is recommended that Leeds continue to take a lead role in bringing together West Yorkshire colleagues to explore opportunities beyond the STP to work collaboratively. This may include further consideration of funding and accountability arrangements with central government for the West Yorkshire health and care system in line with recent policy direction with regard to devolution.

4 Health and Wellbeing Board Governance

4.1 **Consultation and Engagement**

This paper confirms consultations held with the partnership boards and groups referred to. It also takes forward recommendations from the PWC review of Leeds health and care partnership governance. This had broad engagement through three workshops as well as individual consultations with partnership members.

4.2 **Equality and Diversity / Cohesion and Integration**

This paper has no direct implications for equality and diversity. However, it is worth reiterating a key characteristic of good governance is decision making that is supportive of equity and inclusion.

4.3 **Resources and value for money**

The financial challenge facing Leeds is significant with the previously reported estimate of a £723m gap in the projected expenditure based on business as usual and demographic growth over the next five years. This financial challenge is also repeated across the West Yorkshire footprint.

PWC, in their review of Leeds partnership governance, highlighted the significant financial investment in the boards and structures set out in this paper. There is a need to ensure resources (both £ and senior leader time) are used wisely when it comes to partnership working.

Additionally, effective partnership boards and meetings require appropriate resources to support their working. The governance approach in this paper will comprise a significant call on system resources to ensure actions and projects are carried forward. Work is underway to identify the current partnership commitments to 'enabling' resources such as project management, business intelligence, human resources development and Health Partnerships functions and what further requirements there will be, particularly in relation to the recommendations pertaining to the role of PEG.

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

There are no access to information and call-in implications arising from this report. Leeds City Council Corporate Governance has stated there are no changes required to the Council's constitution with regard to proposals set out in this paper.

4.5 **Risk Management**

There is a risk that without effective partnership governance, Leeds will fail to achieve its vision for health and wellbeing and not close the health, care and financial gaps that are articulated in the Leeds Health and Wellbeing Strategy and Leeds and West Yorkshire STPs. Our mitigations are to ensure top level meetings and boards regularly review their governance including role and membership and continue to evolve to ensure the city better meets need.

5 Conclusions

Leeds has a strong history of successful partnership working with effective and innovative governance to support this. The need to develop governance further to achieve our ambitions arises from a number of sources with a particular emphasis on meeting the challenge of enacting local and West Yorkshire placed-based planning to close the three gaps as well as strengthening clinical leadership and making best use of our innovation and research assets to health outcomes.

In order to further develop our governance, the paper posed two key questions: is the Board assured that the right partnership structures are in place? And do they allow the Board influence across the partnership to help achieve our shared ambitions for Leeds?

In considering these questions, this paper has highlighted:

- Firstly, that transparent executive action through PEG linked with Health and Wellbeing Board oversight provides a route to taking forward the Leeds Health and Wellbeing Strategy and delivering the STPs, whilst maintaining sovereignty of decision making in partnership organisations.

- Secondly, that the LAHP provides an appropriate forum to ensure that the city's assets, particularly the research and innovation capacity in our universities, will support the outcomes of the LHWS and STP. Further, working closely with

economic development colleagues to create job opportunities through health innovation will have a longer term role in reducing health inequalities.

- Thirdly, that the recruitment of a representative provider GP to PEG, alongside the three CCG nominations and Chair of a revised Clinical Senate, supports stronger clinical leadership.

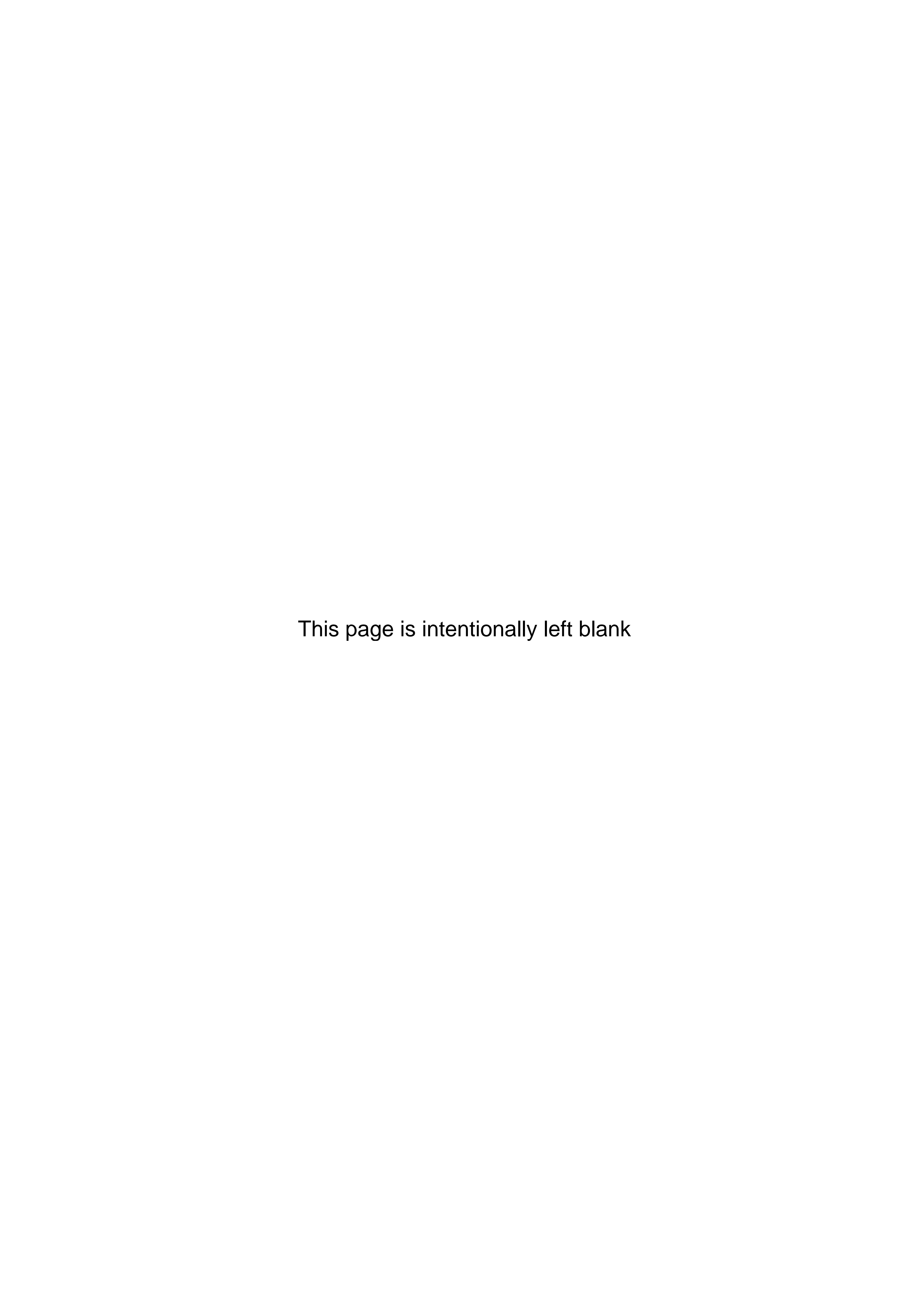
As well as developing the partnership governance and relationships as set out above, senior colleagues must recognise a culture of joint leadership. It is therefore vital that culture, principles and behavioural expectations are understood and continue to be articulated within partnership structures.

In conclusion, the Health and Wellbeing Board should be reassured that with these partnership structures and relationships in place and through continuously developing of place-based leadership, the Board is well placed to act as a 'hub and fulcrum' with clear accountability and effective influence across the partnership. This will support us to work towards our ambition to be the Best City for Health and Wellbeing.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Agree that the right partnership structures are in place and that they help to achieve our shared ambitions for Leeds
- Consider whether the partnership structures create a space in which significant things can happen between or outside of Health and Wellbeing Board meetings (in which the Board has influence)
- Endorse the proposals set out in section 3 of this report
- Consider whether proposals around reference/engagement groups such as the Leeds Academic Health Partnership and Leeds Clinical Senate satisfy issues around clinical voice and leadership
- Request an update on the progress of the Leeds Academic Health Partnership and Leeds Clinical Senate at a future meeting of the Board
- Request a further update and options for governance at a future meeting of the Board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Leeds Health & Wellbeing Board

Report authors: Manraj Singh Khela, Programme Manager / Brian Collier, Transformation Director

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)

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

Summary of main issues

In 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*

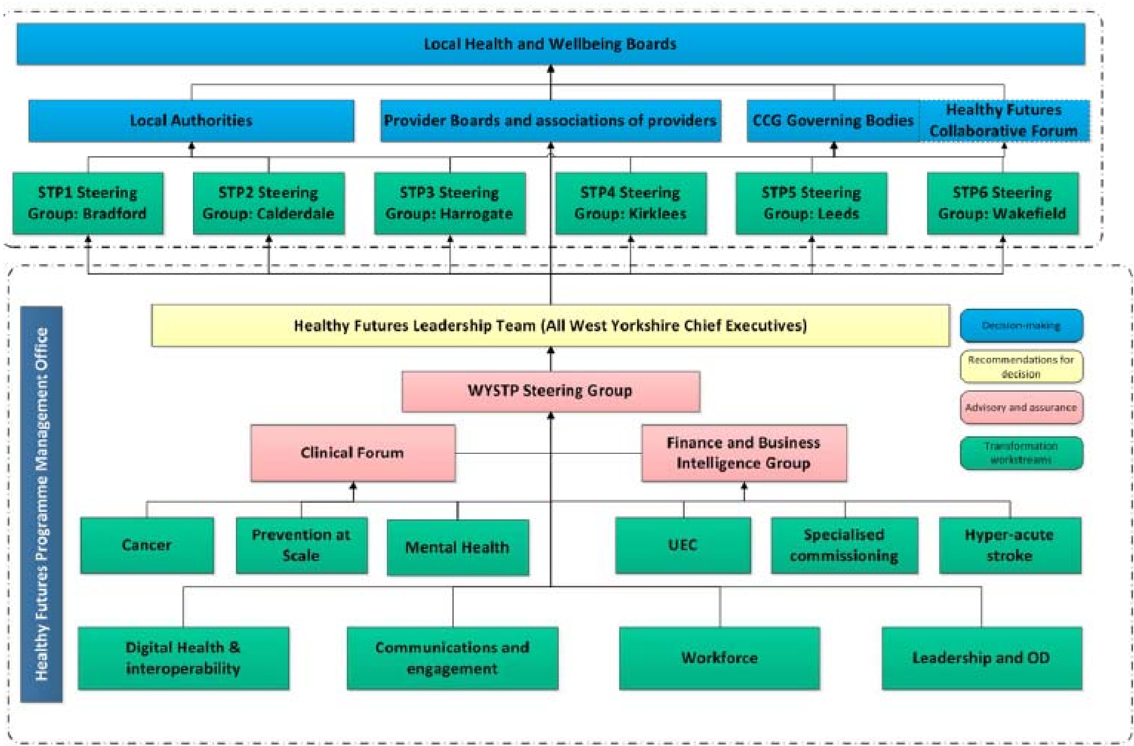
- *We will undertake shared analysis of problems and issues as the basis of taking action*

- *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

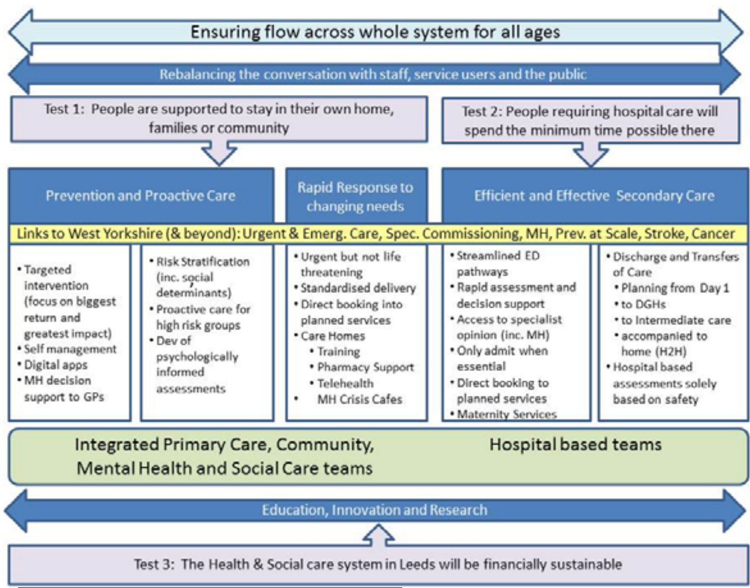
- Digital

- Estates and Procurement

- Communications & Engagement

- Finance & Business Intelligence.

These emerging themes are illustrated in the STP structure diagram below[1]:



[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 21s 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
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: HW1 - Cardiovascular disease (CVD) mortality is significantly worse than for England HW2 - Cancer mortality is significantly worse than the rest of Yorkshire and the Humber HW3 - Deaths from cancer are the single largest cause of avoidable PYLL in the city, accounting for 36.3% of all avoidable PYLL HW4 - PYLL from cancer is twice the level in the deprived Leeds quintile than in Leeds non-deprived HW6 - Suicides have increased	The following NHS Constitutional KPIs have been identified as the areas to focus on to reduce the care and quality gap: CQ1 - Mental Health (including IAPT) CQ2 - Patient Satisfaction CQ3 - Quality of Life CQ4 - A&E and Ambulance Response Times CQ5 - Delayed Transfers of Care (DTOC) CQ6 - Hospital admission rates CQ7 – The capacity gap created by difficulties in recruiting and retaining staff, coupled with a rising demand CQ8 - Difficulties in providing greater access to services in and out of hours

Finance and Efficiency Gaps
The financial gap facing the city (if we were to do nothing about it) would be £723m over the next five years. 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.

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 Cardio-vascular 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 (DTOC*).*

- 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 gaps[2]:

Local delivery: *Leeds*

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

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 the greatest capacity to benefit (need) .
2. Embedding evidenced-based approaches (HoC, 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 LTHT, 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 LTHT
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.

New Models of Care
14. Will deliver improved health and wellbeing outcomes for populations registered with groups of General Practices, planned and provided through an integrated team of health and social care professionals and voluntary sector cross-cutting current provider organisational boundaries. Work is ongoing between commissioners and providers to scope the merits of different functional and contract models.

Impact on 3 gaps

Health and Wellbeing: (Solutions 1, 10, 11, 13, 14)
HW 1 - 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:
CQ1 - Mental Health (including IAPT)
CQ2 - Patient Satisfaction
CQ3 - Quality of Life
CQ4 - A&E and Ambulance Response Times
CQ5 - Delayed Transfers of Care (DTOC)
CQ6 - Hospital admission rates
CQ7 - Capacity gap created by difficulties in recruiting and retaining GP staff, coupled with a rising demand
CQ8 - 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.

Key enablers:
WORKFORCE
Workforce
Informatics
Estates
Education, Innovation, Research
Communication & Engagement

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[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 was 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 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 de-stabilising 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 documents[3]

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

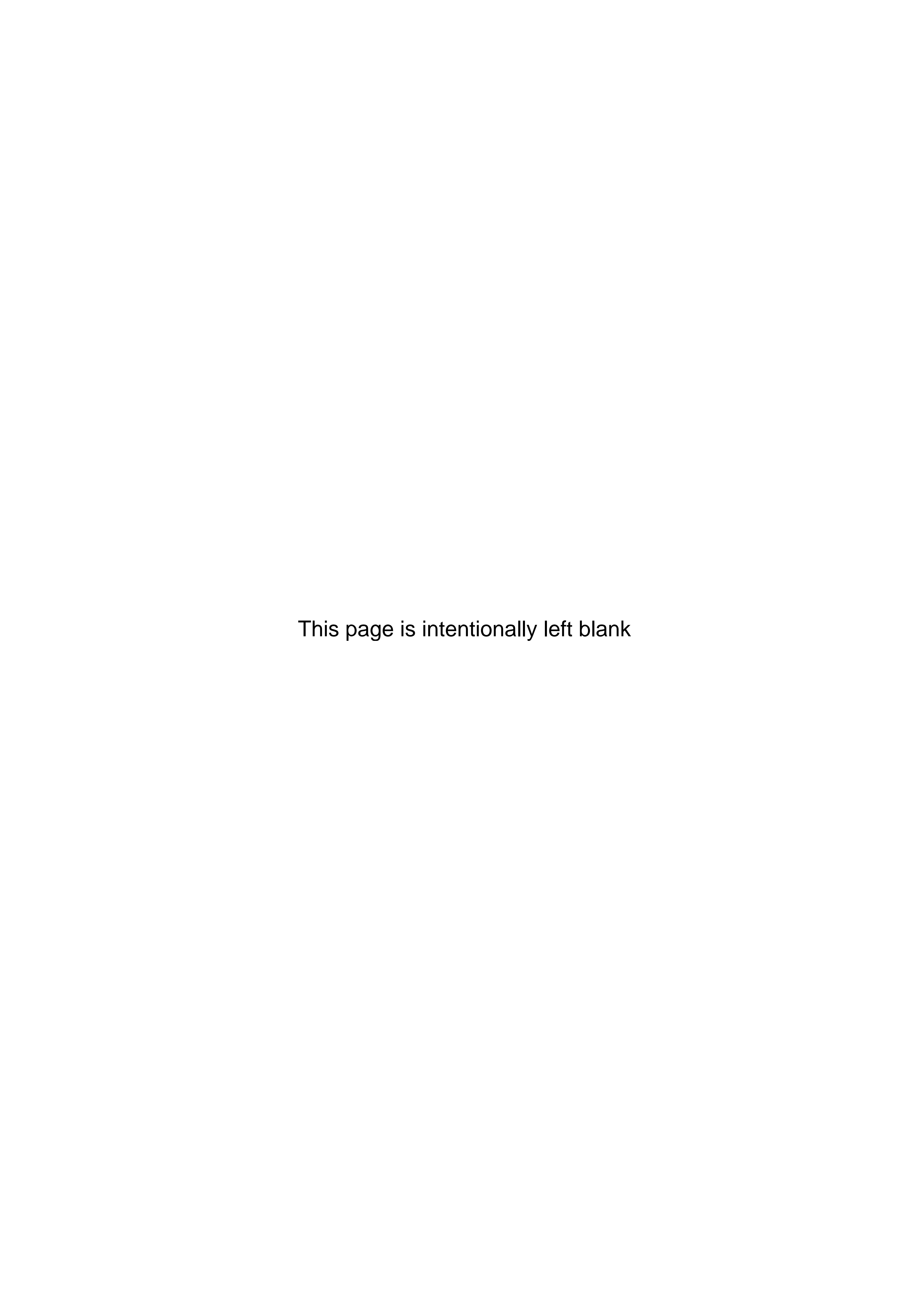
31 August 2016: informal submission of the finance template to regional NHS England Team

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?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues
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.

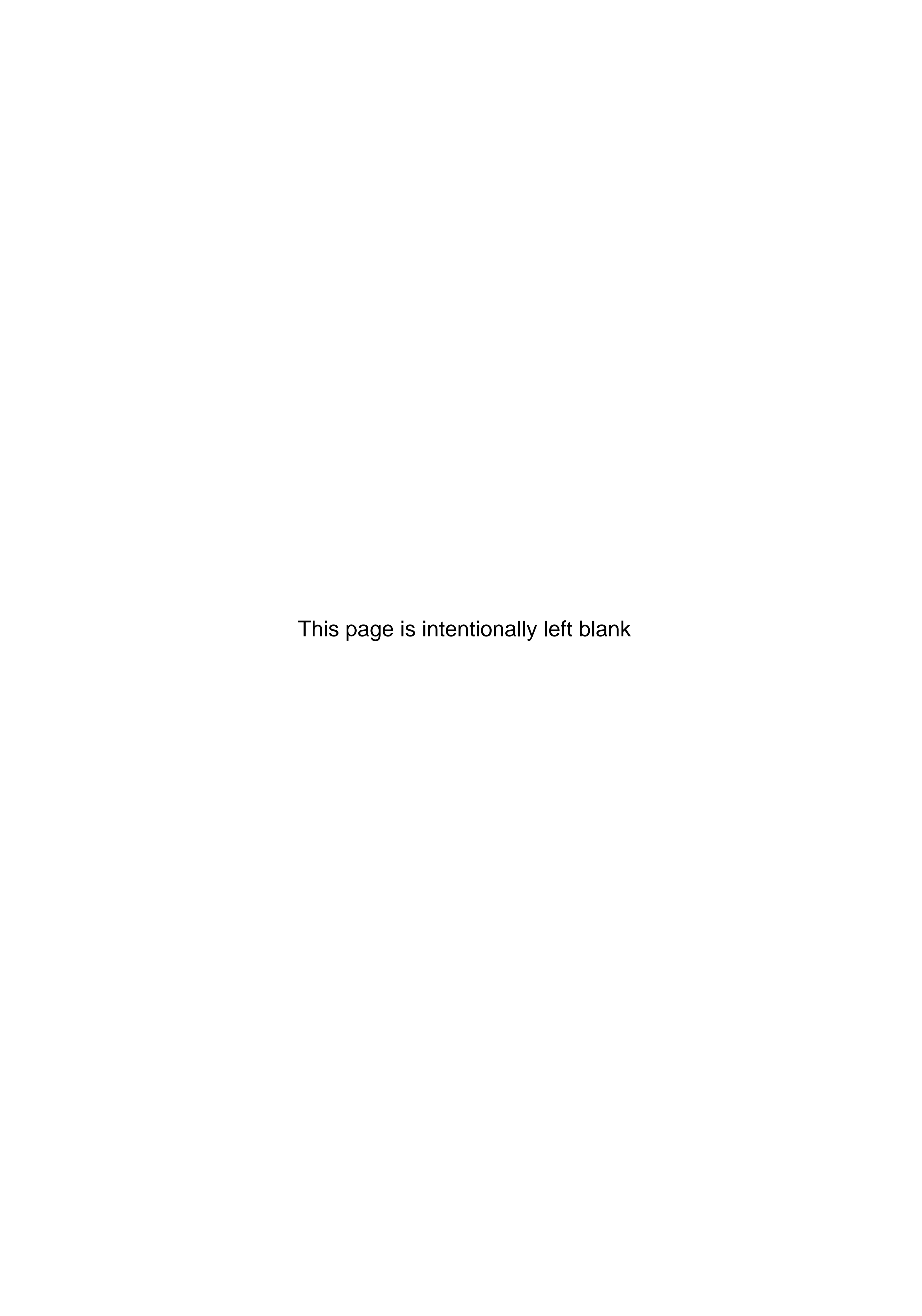
5.3 The LDR is an iterative process and will continue to mature and ensure that it delivers the digital capability required in support of the Leeds Health and Wellbeing strategy.

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

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

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Section 1

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

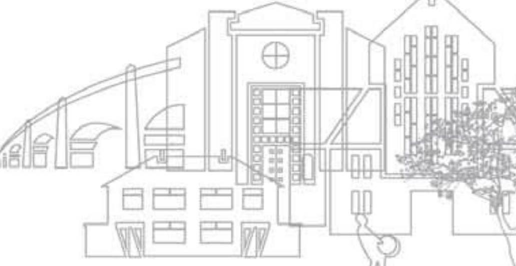
The priority Informatics opportunities described within the LDR are:

- 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 it's 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

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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:

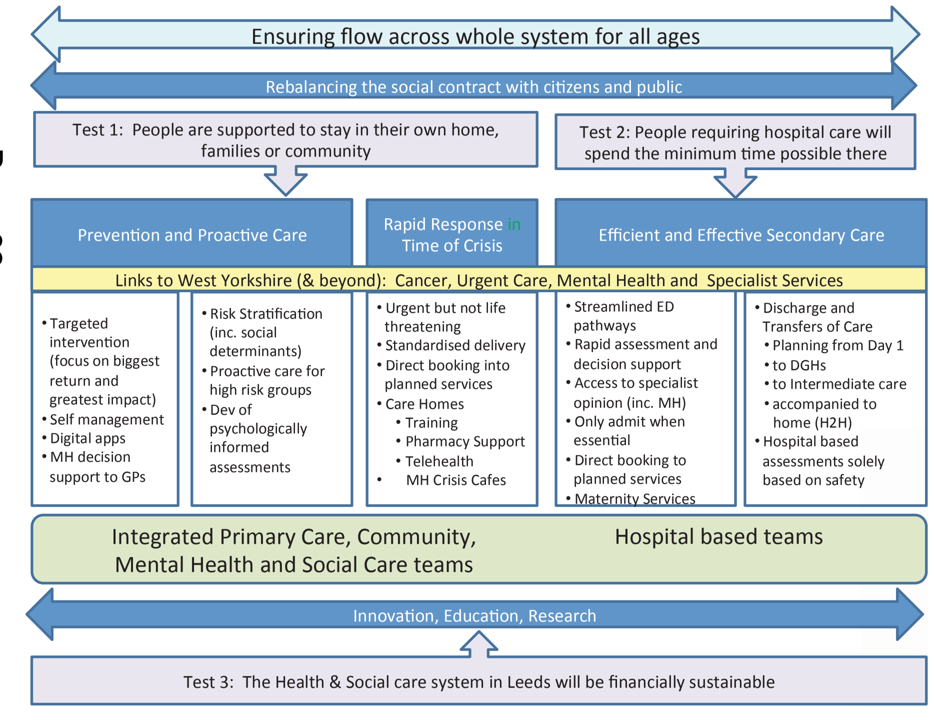
Senior Stakeholders	Leeds Partnership Executive	Leeds Informatics Board
Stakeholders	STP delivery group	CCG Planners group
	City Chief Information Officers group	Specialists to contribute to technical and clinical aspects
	Chief Information Officers linked to organisations and their teams	Lead clinicians 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':



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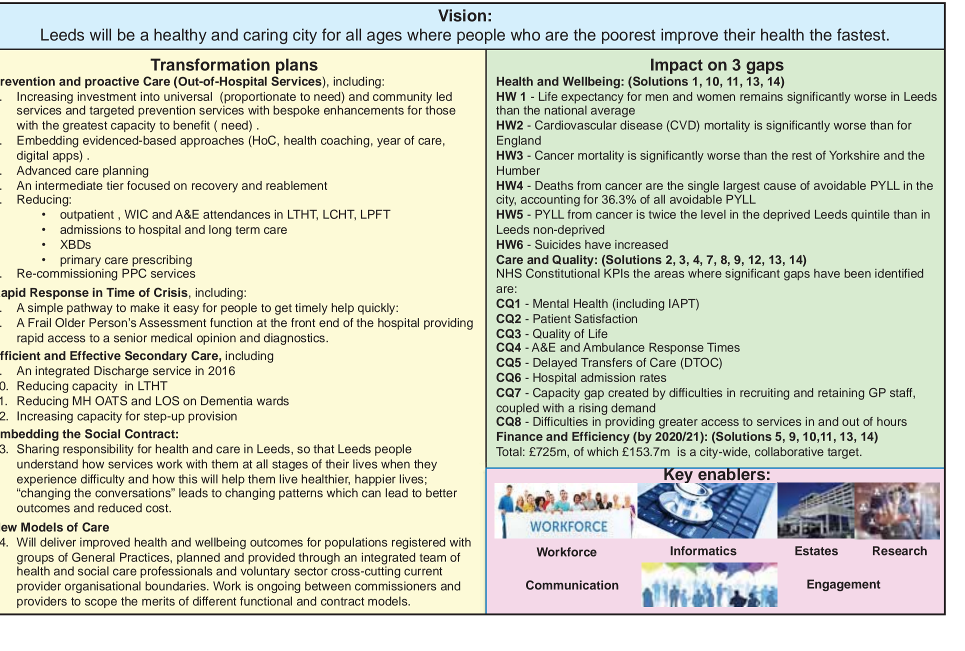
Local delivery: Leeds

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



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

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 the greatest capacity to benefit (need) .
2. Embedding evidenced-based approaches (HoC, 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 LTHT, 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 LTHT
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.

New Models of Care
14. Will deliver improved health and wellbeing outcomes for populations registered with groups of General Practices, planned and provided through an integrated team of health and social care professionals and voluntary sector cross-cutting current provider organisational boundaries. Work is ongoing between commissioners and providers to scope the merits of different functional and contract models.

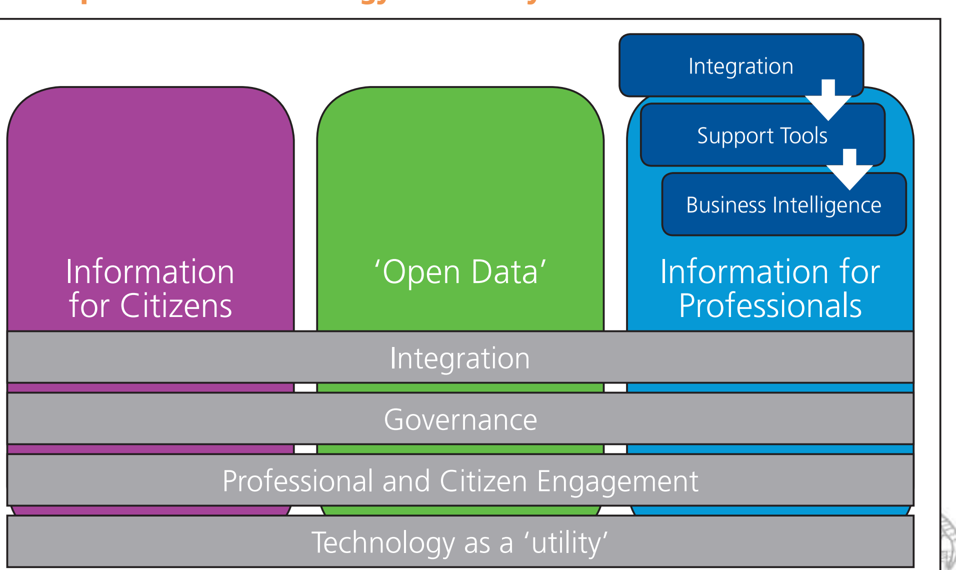
Impact on 3 gaps

Health and Wellbeing: (Solutions 1, 10, 11, 13, 14)
HW 1 - 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:
CQ1 - Mental Health (including IAPT)
CQ2 - Patient Satisfaction
CQ3 - Quality of Life
CQ4 - A&E and Ambulance Response Times
CQ5 - Delayed Transfers of Care (DTOC)
CQ6 - Hospital admission rates
CQ7 - Capacity gap created by difficulties in recruiting and retaining GP staff, coupled with a rising demand
CQ8 - 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.

Key enablers:
WORKFORCE
Workforce
Informatics
Estates
Research
Communication
Engagement



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

Integration
Support Tools
Business Intelligence
Information for Citizens
'Open Data'
Information for Professionals
Integration
Governance
Professional and Citizen Engagement
Technology as a 'utility'

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:

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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:

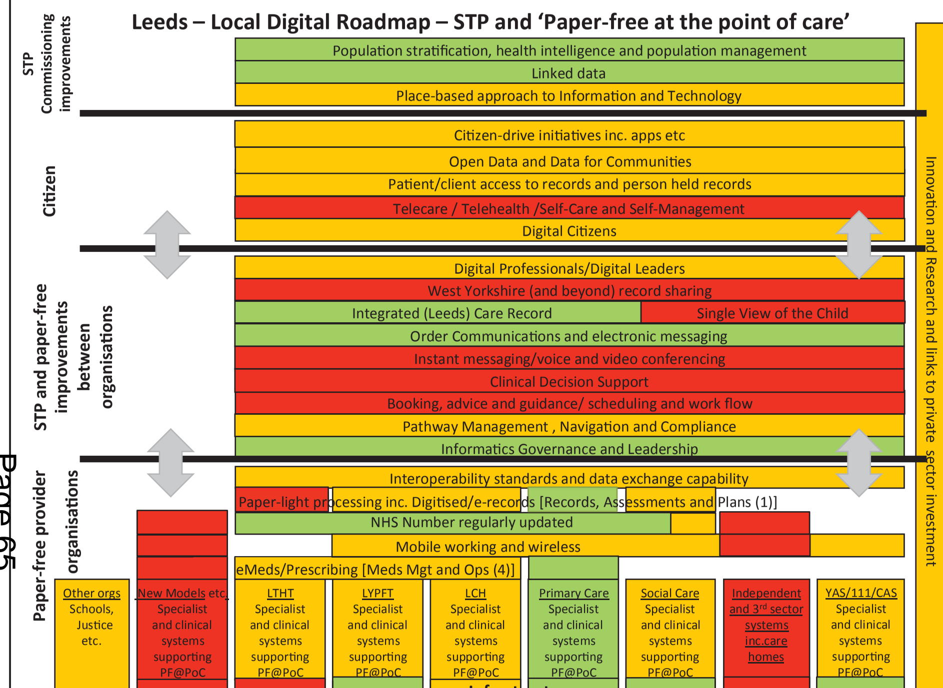
- The use of technology to maximise the contribution that citizens can make to maintain their own health and wellbeing;
- The provision of a robust IT infrastructure that supports 24/7 working across all health and care partners;
- The provision of workflow and decision support technology across General 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 de veloping 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:



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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.

Section 3

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 SystmOne 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

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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:

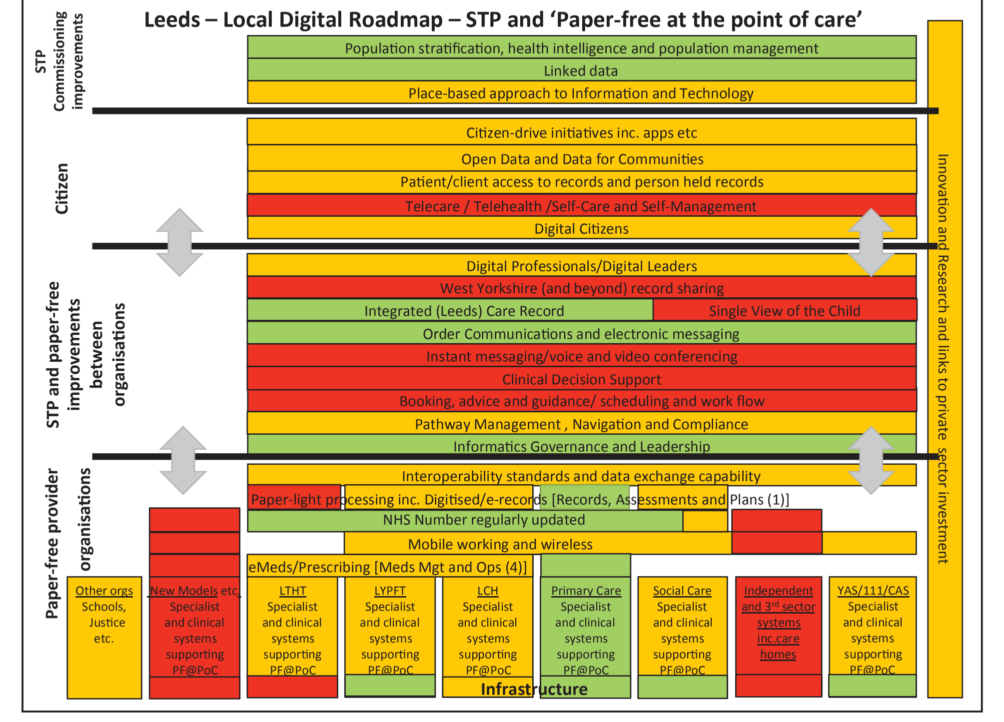
- Digital records, assessments and plans
- Transfers of care
- Order and results management
- Digital medicines management and optimisation
- Decision support
- Remote care and assistive technologies
- Asset and resource optimisation

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).

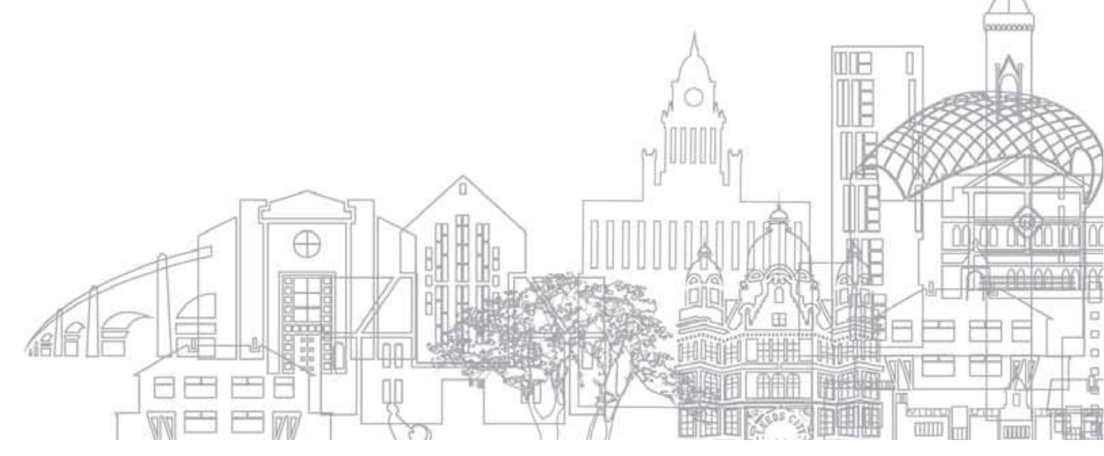
As essential supporting information to the 7 core capabilities required to be progressed, the following templates have been completed:

- 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:

West Yorkshire (and beyond) record sharing

Integrated (Leeds) Care Record

Single View of the Child

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.

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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 SystmOne. Record sharing is relatively mature especially using EDSM within SystmOne 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%.

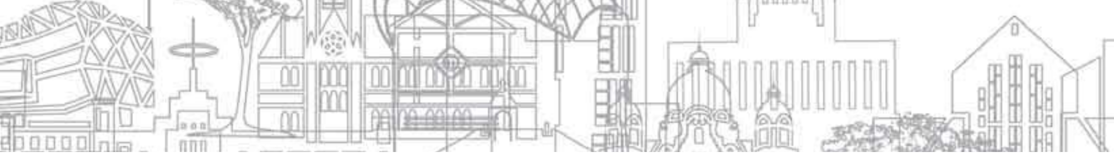
Example showcase initiatives:

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 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.

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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 eprescribing / 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 eprescribing 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 I' 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 I.

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.

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The delivery of an electronic eprescribing 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.

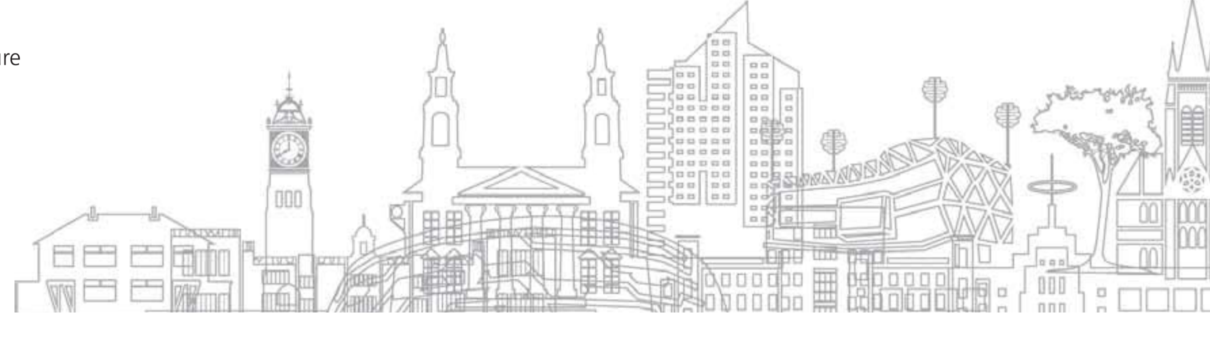
Leeds GPs can see live ward **electronic whiteboard** details of their patients in hospital or lists of patients recently discharged through the LCR. Electronic messages from Leeds Teaching Hospital automatically appear in GP clinical system workflows. General practice use facilities such as the 'frailty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

- Place-based approach to Information and Technology
- Booking, advice and guidance/ scheduling and work flow
- Integrated (Leeds) Care Record
- Single View of the Child

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 his 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.

Section 4

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 specialties 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'.

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Section 5

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.

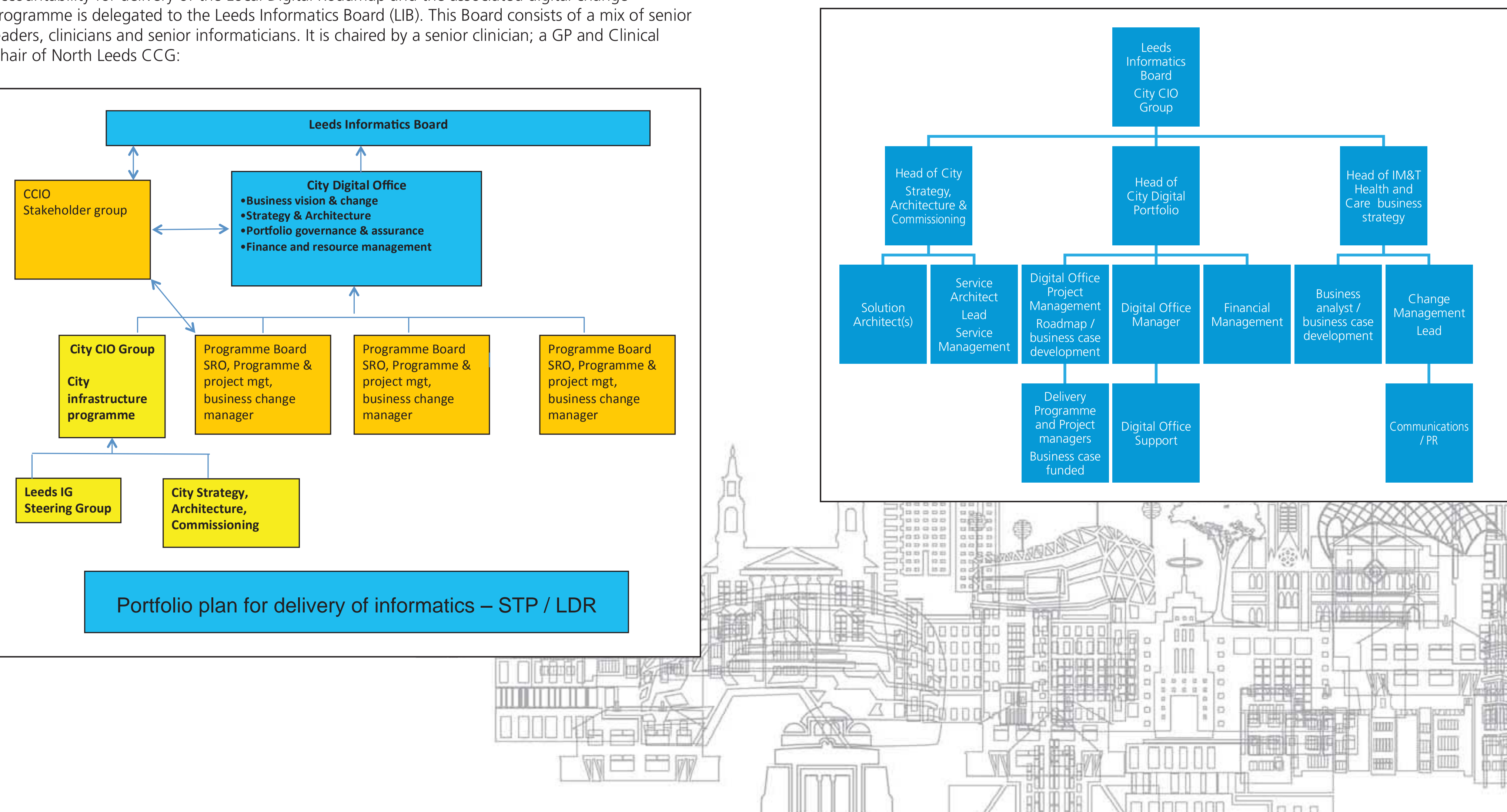
Anticipated sources of funding:

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:

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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.

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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 (LTHT) 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 ass 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 informations 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.

For further information please contact:

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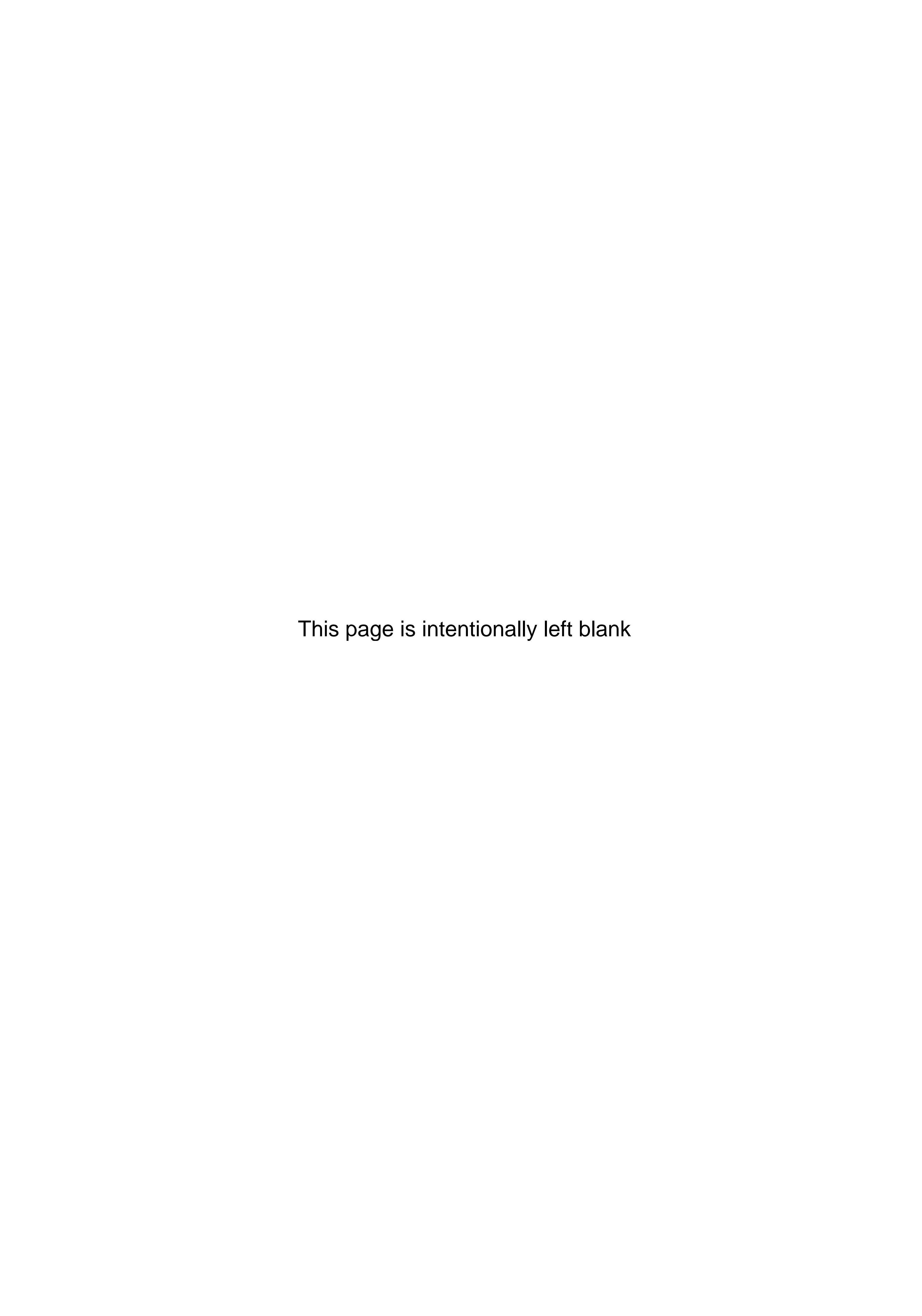
The Leeds Local Digital Roadmap has the following supporting documents:

- 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

Artwork and design by Lindy Dark, Designer at Leeds City Council
and Martin Daniels at Design Daniels Ltd.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Leeds Health & Wellbeing Board

Report author: Steve Hume/Matt Ward

Report of: Steve Hume (Chief Officer, Resources and Strategy, Adults Social Care) & Matt Ward (Chief Operating Officer, NHS Leeds South and East CCG)

Report to: Leeds Health and Wellbeing Board

Date: 06 September 2016

Subject: Better Care Fund (BCF) Update

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

Summary of main issues

The Leeds BCF is in its second year of delivery. In 2015/16 the fund was £54.9 million and supported schemes that were delivering integrated care and preventing hospital admissions. The fund this year is £55.9 million and continues to fund schemes that contribute to reducing non-elective admissions and sustains the provision of integrated health and social care.

The BCF Narrative Plan for 2016/17 was approved by the Leeds Health and Wellbeing Board on 21 April 2016. It was submitted to NHS England (NHSE) in June 2016 and has been 'fully approved' (see appendix 1).

One of the goals of BCF was to reduce non-elective admissions. However, the quarter 4 return shows a continued upward trajectory for non-elective admissions (see appendix 2). There are various reasons for this. A number of key reasons have been identified and an action plan is in place to address these in 2016/17. Non-elective admissions is a complex area influenced by a large number of variables. Several key lines of inquiry are being pursued. There has been growth in the numbers of presentations to A&E. The pathway in and out of hospital has been identified for further scrutiny, which will look at the contribution that community and primary care services do or can make to reduce non-elective admissions. In addition, there have been some changes in the way that non-elective admissions have been classified in the previous 2 quarters.

Further work to understand the complexities and work collaboratively to address the impact and proposed solutions forms a priority within the newly established System Resilience governance structure and the A&E Delivery & Non-Elective Action Plan.

Analysis of both Right Care data and other available intelligence packs is being undertaken for Cardiovascular disease (CVD), Respiratory, Mental Health and Musculoskeletal (MSK). This work covers the whole pathway from early diagnosis to secondary care non-elective and elective admissions and will allow a targeted approach to these areas.

Going forward the BCF Partnership Board will carry on providing the governance that is required to ensure that the investment provided by the BCF meets the dual aims of integrating health and social care and reducing non-elective admissions.

Recommendations

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

1 Purpose of this report

1.1 The BCF Narrative Plan for 2016/17 was presented to the Board on 21 April 2016 where they were approved and then submitted to NHSE in May 2016. NHSE requested further information, which was supplied. The plan was re-submitted in June 2016 and was fully approved. The final plan is therefore being shared to the Board for information.

1.2 Health and Wellbeing Boards are required to provide a report to NHSE on the performance of their BCF on a quarterly basis. This was submitted on behalf of the Board in June 2016 and can be found in appendix 2.

2. Background information

2.1. The BCF is in its second year of delivery. The BCF Narrative Plan for 2016/17 contains an account of what was achieved in year 1 and the key deliverables for year 2. The plan outlines how the eight national conditions are being met locally, how gaps in delivery will be bridged and risks mitigated. This year the plan has been linked to the Sustainability and Transformation Plan (STP), acknowledging that the BCF is only a small part of the wider transformation objectives for health and social care. What the BCF started is expected to be completed by the delivery of the STP.

2.2. The quarter 4 return shows that the trajectory for non-elective admissions is increasing. Addressing this is a key goal for the BCF. The BCF Partnership Board will be looking at the A&E Delivery & Non-Elective Action Plan and the Leeds Urgent &Emergency Care Strategy to making an impact across the system driving the non-elective trajectory down.

3. Main issues

3.1 Performance

3.1.1 Health and Wellbeing Boards are required to return a BCF data collection template to NHS England on a quarterly basis. The Quarter 4 BCF return was submitted in June 2016. The quarter 4 template includes:

- Confirmation that national conditions are being met.
- Planned, forecast and actual income and expenditure figures.
- Reporting on non-elective admissions.
- Reporting on other defined BCF measures (admissions to residential care, reablement, dementia diagnosis and patient experience).
- Reporting of 3 new integration metrics (integrated digital records, risk stratification, personal health budgets).
- Narrative on overall achievements and challenges in delivering the BCF in year 1.

3.1.2 The national reporting template has been designed to fulfil local and national BCF reporting obligations against the key requirements and conditions of the Fund. The Leeds response is provided at appendix 2 for information. The narrative response contained in the last page of the appendix presents a broad overview of the current status of the delivery of the Leeds BCF Plan.

Non-elective admissions have not attained the quarter 4 BCF target. The rate of non-elective admissions in Leeds remains above the national figure. Figure 1 below illustrates the numbers for quarter 4.

Figure 1

	Year 14/15	**Year 2015/16 Plan**	**Year 15/16 Actual**
Quarter 1	17399	16883	17437
Quarter 2	17278	16583	17365
Quarter 3	18145	17259	17227
Quarter 4	17158	16765	21097

3.2 Summary of key Actions:

3.2.1 Leeds commissioners are working with the main acute care provider to understand the reasons for this increase in numbers. An action plan is in place to achieve the following:

- A reduction in the total number of attendances at the A&E department.
- **A reduction in the total number of non-elective admissions.**

- Compliance with the Emergency Care Standard 4 hour target.
- A reduction in the net total of non-elective patients occupying beds.

This action plan has been signed off by commissioners and the provider and are planned to be delivered in 2016/17.

3.2.2 Further lines of inquiry to support system capacity are also being pursued and will include:

- The contributions that community and primary care services do make or can make to reducing non–elective admissions (e.g. analysis of Right Care information in relation to key areas).
- Development of new models of care within primary and community services, with services taking a locality approach.
- Promotion of self-care and long term condition management thorough several workflows.
- The establishment of the System Resilience Assurance Board to incorporate becoming the Leeds Emergency Care Delivery Board.
- A Care Homes workshop for Leeds to share information and better understand the demands and needs of this group of vulnerable patients.
- Progress work on an Integrated Discharge Service, based at LTHT (Leeds Teaching Hospitals NHS Trust), with partners including Leeds Community Healthcare, LTHT and in partnership with Leeds City Council staff. This will support smooth transition out of hospital for patients and reduce delayed transfers freeing up hospital capacity.
- Continued implementation of the out of hospital intermediate care bed strategy to support transfer to assess and appropriate placement of hospital patients deemed medically fit for discharge.
- Continued analysis to improve understanding of the reasons for admission, numbers and flow of non- elective patients in Leeds.
- Review of the walk-in centres and minor injuries units in Leeds.
- Consultation on the development of a refreshed urgent care strategy for Leeds.

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

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

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. The vision that ‘Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest’ underpins the Leeds Health and Wellbeing Strategy 2016-2021. The services funded by the BCF contribute to this aim.

4.3 Resources and value for money

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

4.4 Legal Implications, Access to Information and Call In

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

4.5 Risk Management

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

- Schemes geared towards reducing non-elective admissions do not have the level of impact that is expected
- Failure to achieve non-elective admissions targets

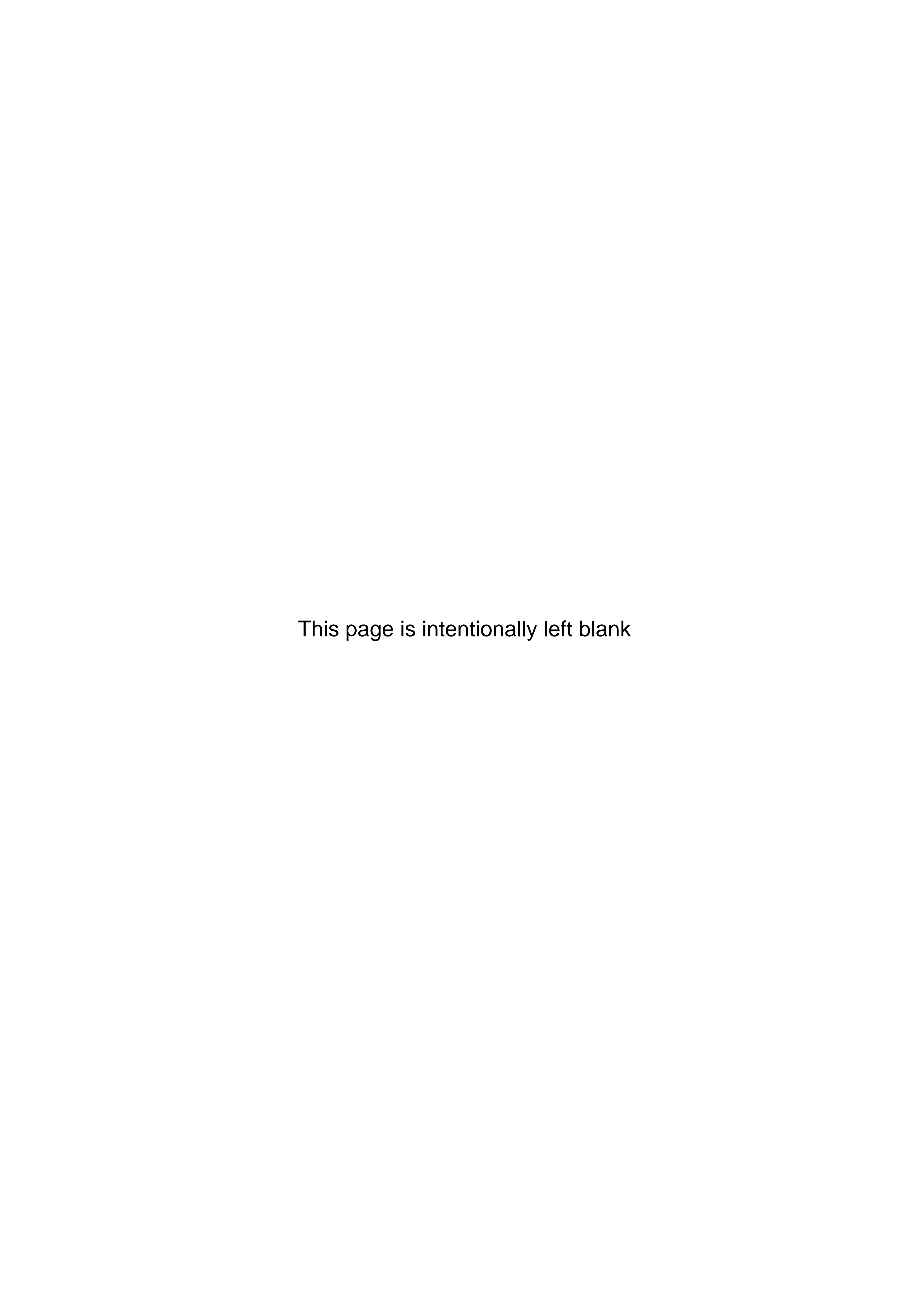
The BCF Partnership Board and Delivery Group have put in mitigating actions to counter these risks.

5. Conclusions

5.1 The BCF forms a component of Leeds' ambition for a sustainable and high quality health and social care system through the achievement of the BCF Narrative Plan for 2016/17. Furthermore, the continued journey of sustained transformation sits within the STP and the BCF will have a role in this through the services that it supports. The continued support and commitment of key leaders in the city is critical to the delivery of current BCF and future STP objectives.

6. Recommendations

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



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Appendix 1

NHS
Leeds South and East
Clinical Commissioning Group

NHS
Leeds West
Clinical Commissioning Group

NHS
Leeds North
Clinical Commissioning Group

LEEDS BETTER CARE FUND

NARRATIVE PLAN FOR 2016-17

30th JUNE 2016

REVISED PLAN

Contents

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Submission Summary

Local Authority	**Leeds City Council**
Clinical Commissioning Groups	**NHS Leeds South and East CCG**
	NHS Leeds West CCG
	NHS Leeds North CCG
Date of Narrative Plan submission 1:	**March 21st 2016**
Date of BCF Planning return submission 1: Date of BCF Planning return submission 2:	**March 2nd 2016** **March 21st 2016**
Value of pump priming 2014/15	**£7.759m**
Value of pooled budget 2015/16	**£54.9m**
Value of pooled budget 2016/17	**£55.9m**
National conditions	**Actions and plans to meet national conditions are in place**

Authorisation and sign off

Signed on behalf of the Health and Wellbeing Board	Leeds Health and Wellbeing Board
By	Councillor Lisa Mulherin
Position	Chair of Health and Wellbeing Board
Date	29.4.16

Signed on behalf of the Clinical Commissioning Groups	Leeds South and East CCG
By	Matt Ward
Position	Chief Operating Officer
Date	29.4.16

Signed on behalf of the Council	Leeds City Council
By:	Steve Hume
Position	Chief Officer Resources and Strategy
Date	29.4.16

1. INTRODUCTION

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

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

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

2. VISION FOR HEALTH AND CARE SERVICES

2.1 Vision

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

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

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

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

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

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

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

2.2 Objectives

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

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

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

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

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

3. THE BCF JOURNEY 2015/16

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

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

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

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

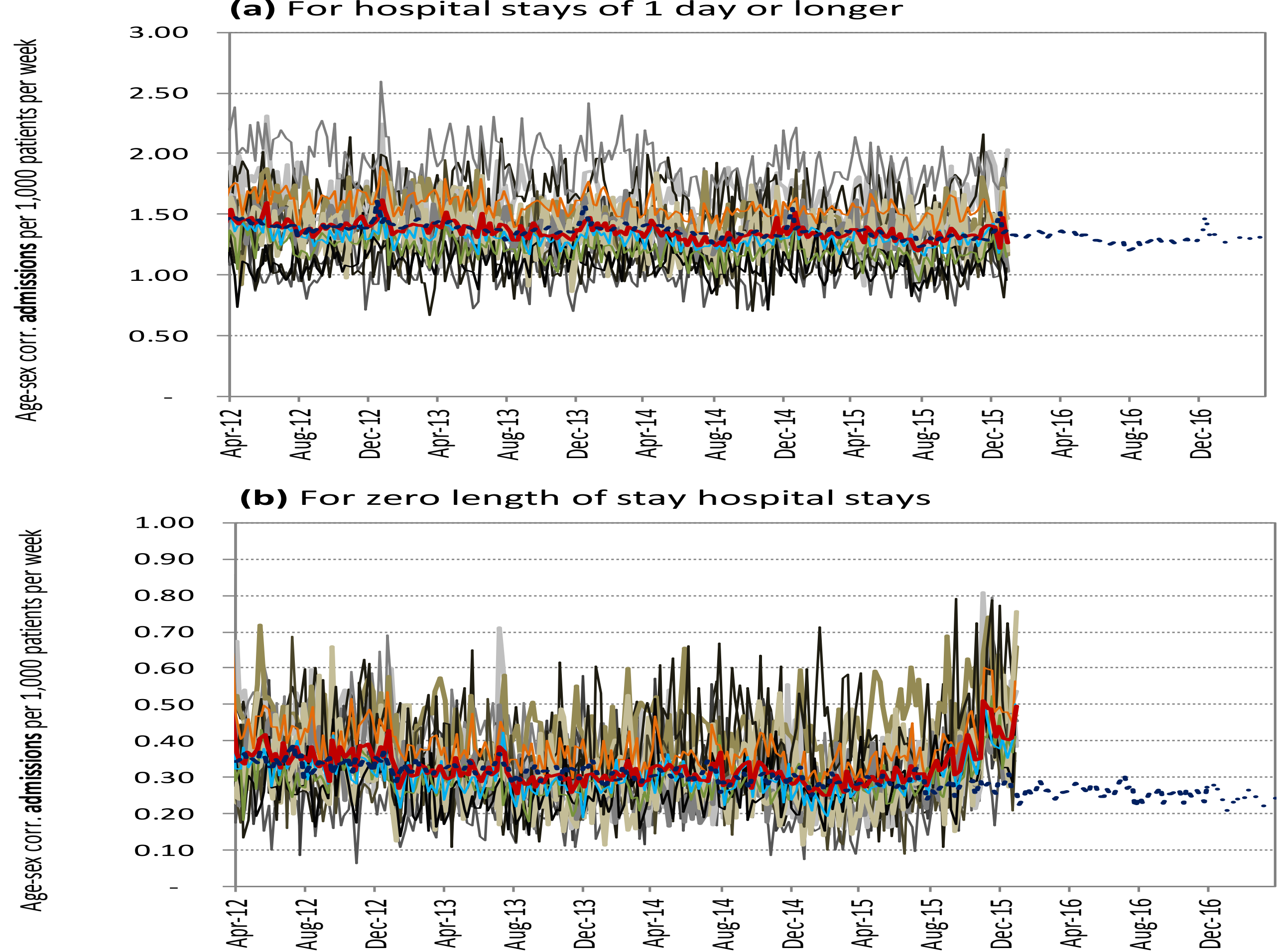
- Reablement services
- Supporting Carers
- Leeds Equipment Service
- 3rd sector early intervention
- Community matrons
- Social care to benefit health
- Disabilities facilities grants
- Enhancing primary care
- Eldercare Facilitator
- Medication prompting - Dementia
- Falls prevention
- Enhancing Integrated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

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

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

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

Figure 1



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

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

Objective 2: Helping people to leave hospital quickly

The following schemes contribute to objective 2:

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

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

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

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

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

The following schemes contribute to objective 3:

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

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

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

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

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

4. The BCF GOING FORWARD - 2016/17

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

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

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

4.1 Issues that the BCF will address in 2016/17

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

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

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

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

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

Completing the work on integrating health and care:

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

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

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

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

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

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

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

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

Reducing demand on NEA:

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

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

Contract negotiations with the Leeds Teaching Hospitals Trust have concluded, the level of performance required for 2016/17 is a priority issue which is embedded in on- going performance monitoring of the Trust. Various actions internal to the Trust as well as services provided by others should contribute to reductions in NEAs for 2016/17. However, if the review that is being done by the SRG points to issues that may take longer to resolve, commissioners have set aside a contingency fund to ensure that system stability is maintained.

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

4.2 What change will the BCF bring?

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

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

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

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

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

5. The BCF POOLED BUDGET

5.1 BCF funding for 2016/17

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

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

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

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

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

5.2 Risk sharing agreement

The Leeds Risk Share Agreement was part of the BCF Partnership Agreement that was signed off in April 2015. This has been reviewed in light of the new contingency fund that has been set up for 2016/17 and can be found in appendix 2.

5.3 Impact on service providers

All service providers who have been affected by the reduction in BCF for 2016/17 were informed in time. Services that were meeting the requirements and goals of BCF and had the potential to be mainstreamed were advised to seek funding via the CCGs planning process for 2016/17. The BCF does not stand alone, commissioners and contract managers have continued to discuss and negotiate impact and changes with providers as part of the planning process for 2016/17.

6. CAPACITY TO DELIVER – WORKFORCE

6.1 Integration in 2015/16

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

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

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

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

6.2 Plans for 2016/17

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

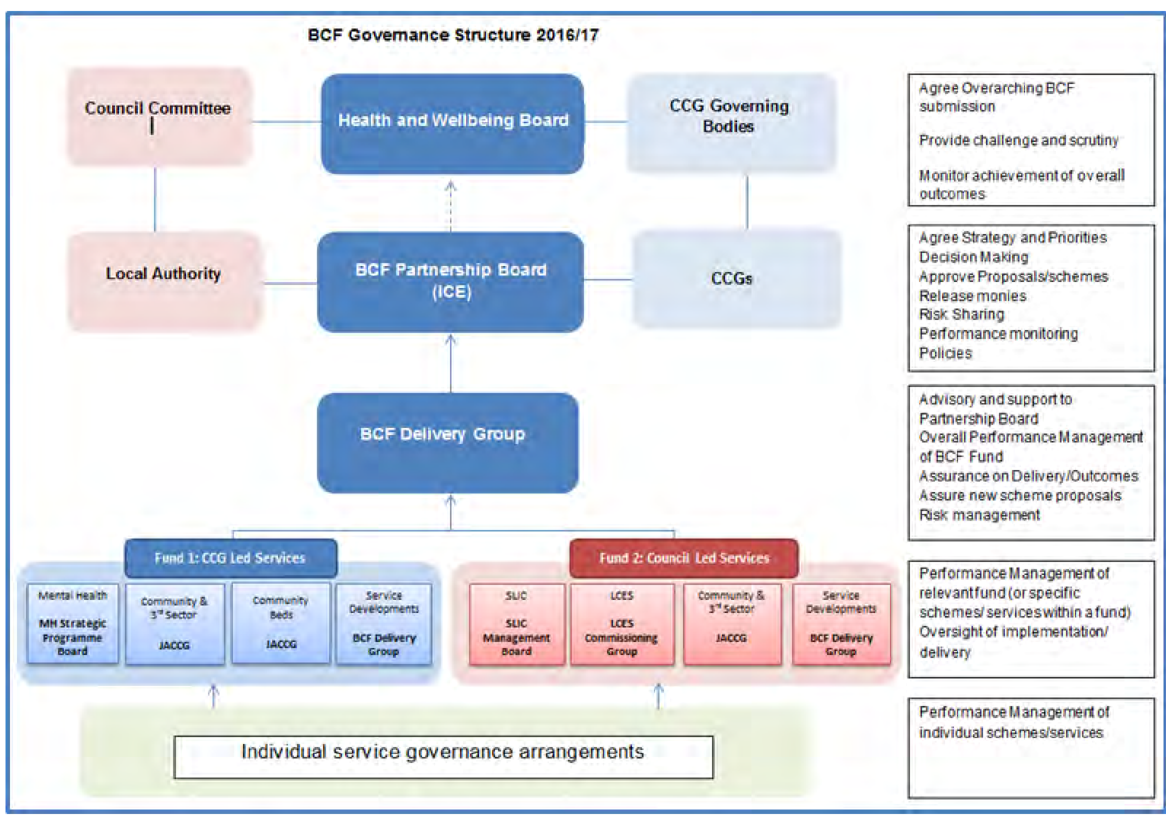
- Expanded and regularly updated Leeds health and social care paid workforce database to support implementation of the STP
- Remodelling of the workforce in localities to support new models of care prototypes
- Greater integration of and multi-skilling of the unregistered workforce through a system wide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

These plans are being taken forward by the city wide strategic workforce group.

7. GOVERNANCE

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

Figure 2



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

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

8. KEY MILESTONES FOR THE DELIVERY OF THE PLAN

In 2015/16 appropriate Governance structures and reporting mechanisms were established, in 2016/17 The BCF Plan will complete the work that began in 2015/16 and ensure a smooth transition into the wider transformation programme under the STP. A clear focus for BCF in 2016/17 is to reduce NEAs and support innovative ways of working that began in 2015/16 that will complete the aims of integration. The following are key milestone for BCF in 2016/17:

- Final BCF Plans submitted having been signed off by the Health and Wellbeing Board on the 21st of April 2016
- The Section 75 Partnership Agreement to be refreshed and submitted to NHSE on the 30th of June
- Review and reshape BCF pooled fund Governance arrangements by July 2016
- Internal audits of BCF Governance and individual schemes due to be completed by July 2016
- STP plans to be submitted on the 30th of June incorporating the strategic aims of the BCF
- Extending coverage of Leeds Care record by March 2017 (see appendix 2h) and embarking on the delivery of the Local Digital Road map
- Mental health transformation plan being implemented in 2016/17, an example is the shared provider CQUIN across mental health to develop a managed provider network with agreed shared outcomes – to improve the integration of services, to be implemented from May 2016.
- NEA performance analysis and recommended plan of action to reduce admissions to be drawn up by the BCF Delivery Group and Partnership Board by September 2016.
- Main provider to achieve 4 of the national standards for the provision of 7 day service delivery by April 2017; extension of 7 day services in primary care

and community services to be implemented from September 2016 onwards (see appendix 2i)

- Delivering the city wide workforce plans that are aligned with the STP; key milestones to be reached by March 2017.

9. MEETING NATIONAL CONDITIONS

9.1 Plans are jointly agreed

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

Leaders of provider organisations were invited to engage with the BCF planning process for 2016/17, particularly in receiving the draft document and having the opportunity to comment. The plan was also taken to the System Executive Group which has all health and social care commissioners and providers coming together to plan and manage the change agenda for Leeds. The draft BCF submission was signed off by the Leeds Health and Wellbeing Board on 21st of April 2016. The BCF will form part of wider planning that is been undertaken in Leeds.

The Disabled Facilities Grant will be used to support the prevention agenda; the Housing Department lead has seen this plan and approved the use of the DFG. Further discussions are taking place with Housing colleagues to explore opportunities for greater collaboration in future developments. This forms part of the wider transformation programme that is being taken forward by the STP.

9.2 Maintaining provision of social care

The health and social care community in Leeds is committed to protect and maintain adult social care services. There is an understanding across health and social care partners of the critical contribution that social care services make to reducing admissions and re-admissions and reducing delayed discharges as well as length of stay in hospitals. It is also accepted that a sustainable quality health and social care system can only be delivered within the city where the care is provided in or as close to people’s homes as possible and hospital care is only considered when absolutely necessary. It is worth noting that considerable investment has already been made through social care in respect of domiciliary care services, telecare, equipment services and adaptations, together with the support of Neighbourhood Networks, which all aim to help people realise their key outcome of living independently in their own home for as long as possible. Increasingly these services are provided on an integrated basis through partnership arrangements between the Council and the

relevant NHS organisations. Our whole systems approach includes a number of strands: integrated health and social care neighbourhood teams; single gateway access for professional referrals: an integrated intermediate care and reablement offer and a rapid response service for urgent referrals. This will continue to be maintained through the BCF and within the wider transformation programme in Leeds.

The approach taken in Leeds, which is consistent with the 2015/16 BCF, is not to restrict the protection of Social Care Services to the resources available within the BCF, but to consider protection of Social Care within the wider concept of the Leeds Health & Social Care £. We are confident that the continuation of this approach will ensure the protection of Social Care in real terms at the levels of protection afforded in 2015/16 and that this will be in accordance with the 2012 Department of Health guidance.

9.3 Delivery of 7 day services

The Leeds CCGs are working with providers to plan for the delivery of 7 day services. LTHT has established a 7 day services working group which the CCG's attend. The CCG's are assured that LTHT have an adequate delivery plan in place to move towards 7 day services in line with the National requirements, see appendix 2i. We have met with the national 7 day team and NHSIQ. There are ten national standards to achieve full 7 day services and LTHT are on track for achieving four of those standards as required in the National trajectory of milestones by April 2017. Nationally, full implementation of all ten standards is required by 2020, and we will work in 2016 / 17 with LTHT to assure ourselves of the plans for full delivery by 2020.

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

Seven day service provision in Primary care is being considered via the Leeds West CCG pilot of 7day access to primary care. 19 Practices are open over 7 days plus twelve hour days in the week. The remaining 18 practices are open for twelve hours daily and many open on a Saturday morning. Evaluation is ongoing and includes

impact on the whole system as well as patient's experience. This is a voluntary scheme for GP practices in Leeds West CCG, so no roll out trajectories are available. We understand that this is now the largest pilot of 7 day Primary care in the UK. We note the national aspirations for 7 day working in primary care and await further information and planning guidance from NHSE, but due to our current pilot and learning being shared across all three CCG's, we believe Leeds will be in a strong position to respond to National guidance once it becomes available. We have also shared the emergent learning on the 7 day primary care pilot nationally at Conferences and had several visits by key figures to the CGG including Sir Bruce Keogh in early 2016.

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

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

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

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

Figure 3 – Milestones for 7 day service delivery in the community for 2016/17

Task	Finish Date
Evaluation of Leeds west 7 Day primary care; all CCG's will consider their plans for 7DS in Primary are	September 2016
LCC Re ablement team to expand further	March 2017
Further review of intermediate care beds	March 2017

9.4 Better data sharing

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

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

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

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

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

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

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

These changes have allowed Leeds to implement integrated systems as evidenced by the Leeds Care Record. These systems have supported the integrated neighbourhood teams which deliver a core part of our vision which is to offer 'wrap around' services at a neighbourhood level. Leeds has produced a video that describes the impact that the Leeds Care Record has had on integrated care. We

interview doctors, nurses and patients, who have seen first-hand the impact of improved information flows to support improved and more timely clinical decisions. (See you tube clip on this link - https://youtu.be/vuZlL38gRIM)

9.5 Joint approach to assessment and care planning

Leeds started developing its integrated community health and social care service in 2012. It became an Integrated Care Pioneer Site in 2013 which helped to accelerate delivery of a joint approach to assessment and care management across the City (see appendix 2 j).

In 2015/16 with the support of BCF funding 13 Integrated Neighbourhood Teams (INT) were established. These teams consist of adult community nursing and therapy (OT, pharmacy), adult domiciliary physiotherapy, intermediate care teams, area social work, community OT and reablement services. City wide health and social care services (e.g.: community geriatricians, joint care management, gateway service) support the INTs. INTs are co-located and serve the same defined population from GP Practice registers. Everyone on the INT caseload and those with a funded care package have a named accountable professional.

Figure 4 – Milestones for consolidating the development of Integrated Neighbourhood Teams in 2016/17

Task	Finish Date
Consolidate common process and procedures, fully embed case management	March 2017
Roll out electronic patient records to all 13 INTs	March 2017

Our emphasis going forward is on an asset based practice – looking at an individual's strengths, community and family connections, linking them into any additional free to access support in their area and only then looking at whether they have any outstanding needs that require the support of statutory services. It's a change in emphasis from assessment and care planning to conversations with citizens, helping them to build their plans on how they live their life. To achieve this, we will move from a focus on neighbourhood teams based in health centres to local people and local workers making decisions on what makes for healthier communities, drawing on the entirety of resource in the area. This shift in approach is planned to take place over the next 18 months but shifting the culture will take another 3 – 5 years of work to ensure it is fully embedded. Workforce development colleagues are supporting us with this and it forms part of the STP programme and the workforce programme 'Working Together as One'.

As part of further developments that will support full integration by 2020, health and social care services are developing a shared front door (currently co-located with a shared front door for hospital discharges but separate arrangements for community referrals). Once joined up people can phone in/refer when someone has a health and/or social care need and they will be triaged to identify the most appropriate initial support. The front door will check for current involvement so that local conversations can be held before a new service becomes involved and an integrated approach agreed. In this way any new assessments required can be built on existing information and in some instances the new referral may not be warranted as members of the team already involved can deal with the new request. This will be in place within the next 12 months.

Figure 5 – milestones for a shared front door

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

Dementia

Joined up services support people developing or diagnosed with dementia. The needs of people with dementia is picked up as part of someone's unique plan and creative solutions are found. Part of the 'culture change' we are seeking to bring about will be to look at how some of this could become everyone's business, where everyone should be skilled (including council one stop shop reception etc.) with the knowledge and information at hand to know when to call in specialists. This forms part of the transformation plan for integrated services. See Appendix 2 f.

For people living with dementia, families and carers, the Memory Support Worker (role described in Appendix 2 Leeds Dementia Pathway) will have a key role in co-ordinating the post-diagnosis care plan for people whose needs can be described as

"supported self-management". As people develop more complex needs, we know that 'case management' is required, at which point a named accountable professional will be in place.

Figure 6 – Milestones for Further development of Dementia support in 2016/17

Task	Finish Date
Lead provider to have an agreed model for integrating specialist and community services to support people with dementia	May 2016
Model to be piloted	December 2017

Mental Health

The mental health transformation plan is being implemented in 2016/17. The plan will see closer integration of mental health services with INTs and other community and primary care services. An example is the work been done in one of our neighbourhoods to build on the existing neighbourhood model to draw on a wider range of local resources to adopt an asset based approach to supporting people within their communities. The parity of esteem aims of Leeds is to ensure that all services respond effectively to the needs of people with mental health problems. The BCF as part of the transformation programme in Leeds includes schemes that support mental health and as is the case across all planning in the City, Parity of Esteem is being actively implemented.

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

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

BCF plans have been subject to extensive consultation including political buy in. Please see appendix 2 for details. This refreshed plan has been seen by the Council's Executive Lead Member for Health Wellbeing and Adults who is also the chair of the Health and Wellbeing Board. She has been briefed on the plan going

forward and will receive the final report before it is submitted on the 3rd of May for approval.

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

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

As the NEA target has not been met for 2015/16, we have decided to set aside a contingency fund capped at £7.5 million which will be used against any negative consequences of a failure to meet NEA targets in 2016/17. As contract negotiations with the Acute Trust and other providers have concluded we can confirm that the contingency fund that we have set aside will be used to mitigate potential negative impacts of NEA.

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

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

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

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

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

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

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

See appendix 2 for the action plan and most recent progress update.

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

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

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

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

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

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

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

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

Investment into out of hospital services are expected to support the maintenance of the DTOC trajectory in 2016/17. See the Planning Template for details of the trajectory.

Appendix 1 – Risk log 2016/7

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*	**Overall risk factor** *(likelihood /potential impact)*	**Mitigating Actions**	**Risk resolution dates & outcome**
Schemes geared towards reducing Non Elective Admissions do not have the level of impact that is expected	2	4	8	• Schemes monitored by the BCF Delivery group. Appropriate actions taken to address any schemes not meeting targets. Owner: Chair/s of BCF Delivery Group (DG)	To be reviewed In October 2016 by the BCF Delivery Group (DG), commissioners of services to take forward recommendations for corrective action recommended by BCF DG
Failure to achieve NEA targets	3	4	12	• The BCF DG to convene a planning summit to address issues and recommend a plan to the BCF Partnership Board • Close monitoring of the target by the System Flow Group • The financial contingency that has been identified and set aside. Owner: Chair/s of the BCF PB.	Planning summit to take place in July 2016 with findings and recommendations to be presented to the HWB and BCF PB in September 2016 Action plan to be constructed and implemented from October 2016
The withdrawal of the Social care capital grant and ring fencing of the DFG could limit our plans for infrastructure projects	2	4	8	• Discussions with Housing colleagues to explore collaborative work in the future • Exploration of other capital funding options with the Council Owner: Chairs of BCF	Conversations to take place with Housing colleagues May 2016.

				DG	
Meeting the DTOC target	2	3	6	• DTOC Plan and strategy for sustained improvement Owner: Chair System Resilience group	Action Plan being implemented, to be reviewed in March 2017
Mainstreaming schemes into the wider transformation programme	2	3	6	• Schemes not funded by BCF in 2016/17 have been placed on the CCG operational planning process for 2016/17 Owner: Chair, Planning and Implementation Group	Schemes to become part of the commissioning plans for 2016/17/18 by May 2016
Capacity to deliver Integration	3	3	6	Implementation of the City wide workforce plan • One Leeds workforce plan based on STP • All provider organisations to engage their workforces with a similar introduction to the concepts of working 'with' people and working as 'one'. • 1000 apprentices in Leeds health and social care • OD interventions commissioned to support multi-disciplinary teams • 100 nursing places, with a focus on practice and community nurses Owner: Chair of the City Wide Workforce Workstream	These actions all have April 2017 as the milestone for delivery

Implementation of the Mental Health Transformation Plan	2	3	5	Delivering the MH improvement programme 4 key areas: -Crisis Care Concordat -Information -Redesign of Community Based MH Services - Integration of CYP and adult services Owner: Chair MH Partnership Board	First phase delivered by April 2017
Extending coverage of information technology	2	3	5	• Full roll of Leeds Care Record. • Delivering the Local Digital Road Map Owner: Chair Leeds Informatics Board (for LDR) Partnership Executive Group (for LDRM)	• Full coverage of LDR by April 2017 • The city Chief Information Officers (CIOs) and Chief Clinical Information Officers (CCIOs) across Leeds jointly proposed a city-first (or place-based) strategy and an integrated and open-platform based approach to achieving the vision. This was signed up to by the city-wide Transformation Portfolio Board in December 2015 and confirmed by the Partnership Executive Group in May 2016. All parties have signed up to a set of digital design principles

Appendix 2 – Reference documents

a) Case Management Framework
b) Risk Share agreement - Extract from the Leeds BCF Partnership Agreement
c) BCF Partnership Board Terms of Reference
d) Engagement in developing the BCF
e) 'We Are Open' booklet
f) Dementia - The pathway in Leeds
g) DTOC plan and update
h) Leeds Care Record deliverables
i) Lead provider and community action plan for 7day service
j) Leeds Integrated Care Pioneer case study

CASE MANAGEMENT FRAMEWORK

What is case management?

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

Definition

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

Key messages

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

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

Interventions include

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

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

Agree common population

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

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

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

Enablers of case management

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

Case Management Guidance

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

Extract from the Leeds BCF Partnership Agreement

THIS AGREEMENT is made on 1st April 2016

PARTIES

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

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

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

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

SCHEDULE 4 – RISK SHARE AND OVERSPENDS

Risk Management Arrangements & Financial risk sharing policy: Better Care Fund between NHS Leeds South & East CCG, NHS Leeds West CCG, NHS Leeds North CCG and Leeds City Council for the financial year 2016/17

Purpose:

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

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

Partnership Agreement:

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

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

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

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

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

1. For 2016/17 the resources will be held under a partnership agreement. This agreement will include two pooled funds (via Section 75), one hosted by the Local Authority and the other by the CCGs. BCF services have been allocated to either pooled fund based on the most appropriate lead commissioner. Within the BCF partnership agreement, non-pooled funds (nominal funds) will also be used as the partnership vehicle for services which are inappropriate for inclusion in a Section 75. The BCF Partnership Board will be responsible for approving virements between the various pooled/non pooled funds.

2. Contingency arrangements (circa £7.5m in 16/17) will be developed to meet a range of financial risks affecting the BCF e.g. effects of increasing demand, changes to legislation and those risks outlined in the BCF risk register. However in line with national guidance, the first call will be against the (risk) of failure to deliver the planned reduction in non-elective admissions. In 16/17 the aspiration based on an average price equates to £5.1m. This will be managed through monthly monitoring of the non-elective spend and whilst there are currently no plans to amend the overall BCF if the planned savings are not at the expected level then the BCF will need to be amended to ensure the non-elective risk is accounted for through amending the existing schemes and increasing the contingency.

3. Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board). The financial values are outlined in the BCF Partnership Agreement (£56m comprising funds from both the CCG allocations and council funding).

4. The BCF Partnership Board under the guidance of the Health and Wellbeing Board will make joint decisions, within the limits delegated to its members by their respective organisations, about the best use of the Invest to Save Funding which currently equates to £8.4m to support integration and maximise reduction in acute admissions. BCF Partnership Board therefore will be responsible for the final agreement and detail behind these agreements which will eventually form part of the full partnership agreement for 16/17. The implementation and ownership of the Invest to Save schemes will be managed under the Transformation Board governance arrangements.

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

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

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

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

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

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

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

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

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

10. The pooled funds will be managed at fund level and delegated to Pool Fund Managers. Non-pooled funds will be managed at service level and delegated to the Budget holder for each individual service. The £56m BCF will in effect be managed as four budgets plus the contingency as per the BCF governance arrangements.

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

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

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

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

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

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

a. The Pooled Fund Manager (or Budget holder for non-pooled funds) will be held accountable for ensuring their overall fund remains in budget.

b. At the discretion of BCF Partnership Board - any underspends from other pools or invest to save schemes could be allocated to support a pressure in a pool

If no further mitigations exist in other pools or the contingency is exhausted then this would be a serious problem for the partners to resolve. The partners will need to provide in year funds to resolve the issue.

Non Elective (emergency) Spend Within the BCF:

13. Non Elective Spend/budget within the BCF is reflected in the following schemes

a. £7.5m Contingency (against not delivering planned reductions)

b. £2.8m Admission Units, (improve patient flow and reduce costs)

14. There are many schemes outside of the BCF within the CCGs that are focusing on reducing non elective emergency admissions and it will be difficult to link a particular scheme to the impact (i.e. a BCF or a non BCF scheme). This will be attempted through monitoring of individual schemes.

15. The Non-elective (emergency) budget will be managed as follows.

a. 15/16 Forecast Non Elective Expenditure - £114.1m

b. 16/17 Planned Non Elective Expenditure - £118.4m

c. BCF Admission Unit Plan - £2.8m

d. BCF Contingency - £7.5m

16. It is expected the non-elective expenditure will reduce in line with the 14/15 outturn of £110.9m. If the expected savings are met the value of the funds held within the BCF will either be reinvested or used as a cost improvement saving to be split between the partners based on the contribution made between the four partners. CCGs will retain any further underspends at CCG level.

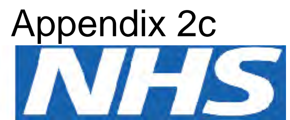
17. There will be a separate and regular evaluation and review of schemes throughout each year which will help mitigate the risks for future years and ensure effectiveness and value for money.

18. The appropriate accounting standards will apply in relation to any joint arrangements that are put in place.

19. Each of the CCGs and the Local Authority will recognise its share of the pooled budget in its individual accounts and memorandum accounts will be produced. The pool and this agreement will be subject to the usual audit and annual reporting requirements, for which differences in accounting treatment will need to be recognised in line with auditor's advice. There needs to be a commitment to produce memos in line with all parties audit requirement

20. The BCF pool may be increased in 17/18 onwards beyond the mandatory level and the risk share arrangements will need to be reviewed in the light of any changes to this pool.

If any other organisations become part of the pool they must participate in the sharing of the financial risks according to this agreement



Better Care Fund Partnership Board

Terms of Reference

Version:	DRAFT 1.21
Approved by:	Leeds CCGs' Governing Bodies and Leeds City Council Executive
Date Approved:	
Date Issued:	
Review Date:	

1 PURPOSE

The Better Care Fund (BCF) Partnership Board (‘the Partnership Board) is a sub-group of the Leeds Integrated Commissioning Executive.

The purpose of the Partnership Board is to oversee the BCF partnership agreement between the Leeds CCGs and Leeds City Council and to monitor the Better Care Fund.

The BCF Partnership Board will act as a forum for reviewing and considering plans and proposals for BCF funding and promoting the agenda on integration.

The Partnership Board will make recommendations to the Health and Wellbeing Board in terms of the strategic planning for the Better Care Fund.

2 MEMBERSHIP

2.1 The Partnership Board will consist of senior officers of the Leeds CCGs and Leeds City Council:

Leeds CCGs:

- Clinical Chair and Chief Accountable Officer, Leeds North CCG
- Clinical Chair and Chief Accountable Officer, Leeds West CCG
- Clinical Chief Officer (Accountable Officer) and Chief Operating Officer Leeds South and East CCG
- Chief Finance Officer, Leeds South and East CCG (On behalf of the 3 CCGs)

Or a nominated deputy

Leeds City Council:

- Director Adult Social Care, Leeds City Council
- Director of Public Health, Leeds City Council
- Deputy Director, Adult Social Care Commissioning, Leeds City Council
- Director of Resources, Adult Social Care, Leeds City Council

Or a nominated deputy

Other officers may be asked to attend meetings of the Partnership Board as required

2.2 The Partnership Board will be jointly chaired by a CCG Chair and the Director of Adult Social Care, Leeds City Council

2.3 Other senior officers of the CCG and Council may be invited to the meeting as required.

3 QUORUM

3.1 The quorum for the Partnership Board shall be two CCG representatives and two Leeds City Council representatives.

4 VOTING

4.1 The Partnership Board will not be required to formally vote.

The Partnership Board will be expected to reach a consensus when agreeing matters of business. Where it is not possible to reach a consensus the matter will be referred to the CCGs' Governing Bodies/Council Executive Board for consideration.

5 SECRETARY

5.1 The support functions required to service the Integrated Commissioning Executive will be extended to include support to the Partnership Board.

6. CONFLICTS OF INTEREST

6.1 Declarations of interest will be a standing item on all meeting agendae.

6.2 Attenders who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chair of the meeting will decide the course of action required, which may include exclusion from participation in the discussion.

6.3 All declarations of interest and actions taken in mitigation will be recorded in the minutes.

7. FREQUENCY AND NOTICE OF MEETINGS

7.1 Meetings will be held at least quarterly but more frequently if required.

7.2 Items of business to be transacted and all supporting papers for such items for inclusion on the agenda of the Partnership Board need to be notified to the Chair of the meeting at least 7 clear working days (i.e. excluding weekends and bank holidays) before the meeting takes place.

7.3 The agenda and supporting papers will be circulated to all members of a meeting at least 5 clear working days before the date the meeting will take place.

7.4 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

7.5 Minutes will be issued at latest 10 working days following each meeting.

8. REMIT OF THE COMMITTEE

8.1 All decisions made within the Partnership Board are through the authority delegated to individual members of the Partnership Board through their host partner organisation, and the governance of such decisions is through the mechanisms of those organisations.

8.2 The Partnership Board is authorised to create sub-groups or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Partnership Board remains accountable for the work of any such group.

9 DECISION MAKING

9.1 The Partnership Board is authorised within the limit of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

- Authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the partners to any Pooled fund; and

- Authorise a Lead Commissioner to enter into any contract for services necessary for the provision of services under an individual scheme

9.2 The following decisions are reserved for the CCG Governing Bodies and Council Executive Board:

- Approval of schemes beyond delegated limits
- Financial contributions and budgets
- Changes to the partnership agreement
- Budgets for individual schemes
- Virement and transfers beyond delegated limits
- Contract awards beyond delegated limits

10. RESPONSIBILITIES AND DUTIES

The Partnership Board will:

10.1 Provide strategic direction on the individual schemes

10.2 Monitor financial and activity information

10.3 Review the operation of the partnership agreement and performance manage the individual services

10.4 Monitor the implementation of and outcomes from individual schemes within the Better Care Fund

10.5 Review and agree annually revised schedules as necessary

10.6 Review and agree annually a risk assessment and Risk sharing arrangements

10.7 Request such protocols and guidance as it may consider necessary in order to enable each Pooled Fund Manager to approve expenditure from a Pooled Fund

10.8 Approve proposals/schemes within delegated limits

10.9 Approve release of monies in relation to approved schemes

10.10 Review quarterly and annual returns

10.10 Review and recommend plans for the BCF to the Health and Wellbeing Board, CCG Governing Bodies and Council Executive Board

11. REPORTING and ASSURANCE ARRANGEMENTS

11.1 The Partnership Board will report to the Governing Bodies of the Leeds CCGS and the Council Executive Board

11.2 Minutes from the Partnership Board meetings will be submitted to each partner organisation.

11.3 A quarterly assurance report on the implementation, delivery and outcomes of the BCF will be submitted to a specified group or committee within each partner organisation.

11.4 An annual report on the operation of the partnership agreement will be submitted to each of the Leeds CCGs' Governing Bodies, the Council Executive Board.

11.5 Quarterly reports and annual returns for the Better Care Fund will be submitted to the Health and Wellbeing Board

12. BCF DELIVERY GROUP

12.1 The Partnership Board will approve the terms of reference of the BCF Delivery Group which will provide advice and support to the Partnership Board

12.2 The Partnership Board will receive regular reports from the BCF Delivery Group

END

ENGAMENT IN DEVELOPING THE BCF PLAN

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

BCF engagement

This plan has been jointly developed by all of the health and social care organisations (including both statutory and third sector providers) across Leeds that work to deliver outcomes for the Leeds Joint Health and Wellbeing Strategy and thus link into the Leeds Health and Wellbeing Board.

The development of the BCF plan has been led by the Integrated Commissioning Executive. It has been developed through a series of BCF-specific, well-attended workshops with attendance drawn from provider and commissioning organisations from across the city. It has been supported by a number of existing boards, aligned to the Health and Social Care Transformation Programme Board, which have senior representation from all service provider organisations.

As well as senior representation, membership also includes frontline staff from medical, nursing and mental health backgrounds, third sector representatives, patient and carer representatives, other health and social care professionals, and colleagues from Public Health.

Since the first draft was submitted in April, there has been further consultation with providers:

- Series of meetings between CCG lead officer for the BCF with NHS provider chief executives
- Presentation to and discussion at the Directors of Finance forum, aligned to the Transformation Board –opportunity to further focus on quantifiable savings and financial impact on the provider landscape and agreement to jointly sign off the schemes through the detailed business case and implementation phase
- As part of the “exemplar” submission process in July, there were a further series of meetings with providers focussed specifically on the BCF submission. We now have representation from providers on the BCF task and finish group, and as of October they will be represented at the HWBB.
- Establishment of BCF Metrics/Intelligence group which has representation from Leeds Teaching Hospital Trust and Leeds Community Health Trust.
- Broadening of the BCF Task & Finish Group to include representation from Leeds Teaching Hospital Trust and Leeds Community Health Trust.

We have also consulted with Leeds City Council’s Executive Board and Health and Wellbeing and Adult Social Care Scrutiny Board on the BCF submission.

Ongoing engagement

In addition to the specific work to develop the BCF, for the past three years, Leeds has operated a Health and Social Care Transformation Board that comprises the Chief Executive (or equivalents) from all of the city's commissioner and provider bodies, plus third sector representation. Additionally, we are dedicated to maintaining parity of esteem between physical and mental health services.

Significant engagement work has been completed in Leeds CCGs in primary care to engage with them on the urgent need to transform services. Applications to the Prime Minister's Challenge Fund have included additional funding requests to extended and out of hours services, provide flexible access to clinicians via technologies such as Skype, better joining up of urgent care and out of hours care and improved access to telecare so people can live for longer in their own homes. Continuing to roll out new technologies with primary care forms part of the "enhancing primary care" scheme of our BCF.

Additionally, we are committed to clinical leadership and engagement across all sectors. In secondary care, the CCGs are working with acute hospital consultants and the local clinical senate to look beyond our shores at models of healthcare overseas, at the Intermountain Healthcare organisation in Utah, United States. Through this continued work, our aim to bring back to Leeds the best examples of good practice and innovation and this will continue to inform the schemes of our BCF.

ii) primary care providers

As above

iii) social care and providers from the voluntary and community sector

In addition to information covered in previous sections of this submission we have undertaken:

- Consultation event with over 25 members of Healthy Lives Leeds, the 3rd sector representative collaborative.
- Adult Social Care's Directorate Leadership Team (DLT) and Departmental Senior Management Team (DSMT) have been consulted at various stages of the development of the BCF through presentations at the DLT and DSMT as well as having representation as part of the BCF Task & Finish Group.
- All of this is underpinned by extensive consultation, engagement and co-production with service users, carers and citizens

This takes part in regard to the BCF within 4 levels:

1. Ensuring we take heed of previous consultations. Service users and carers have expressed their frustration at being asked the same questions over and over again, especially where they do not see any change, or even get feedback as to what their contributions resulted in. We have therefore in relation to each scheme and the overarching 'direction of travel' within the BCF made extensive use of previous engagement activity. For example, the proposals in regard to dementia services come directly from the priorities within the Leeds @Living Well with Dementia strategy, which was produced via a series of major public events, meetings with people with Dementia and their carers and specific feedback from groups such as the Leeds Dementia Peer Support group and organisations with a strong user voice such as the Alzheimer's society and Leeds Older People's forum. Similarly, we have used the extensive consultation with Carers on the Leeds Carers Strategy – to be published later this year – to inform the proposals around Carers. This consultation included distribution of thousands of questionnaires, backed up by focus groups and again attendance at meetings, supported by Leeds Carers Association.

2. Engagement of service users throughout the entire commissioning or service transformation process. For example, the proposals around Homecare have arisen out of the wider engagement on the delivery and re-commissioning of Homecare in the city. For this process, all users of ASC's contracted home care services (over 2,340) were invited to participate in the process. We also contacted other groups who we felt would particularly want to contribute; these included disabled people, older people and people from BME communities. To ensure effective engagement, people were offered different methods to gather their views From this:
    - A small group of users, supported by an independent User organisation, joined the Strategic Home Care Advisory Group chaired by the Lead Member for Adult Social Care
    - Face-to-face discussions with 15 service users on a 1-1 basis, took place and over 40 people in focus groups.
    - A survey of service users and carers which was completed by 79 users

The information from this consultation has been used to inform both the BCF and ASC and CCG Commissioning plans for Homecare.

3. Engagement with strategic boards with oversight of particular work streams Each of the schemes can be placed within an existing commissioning/service transformation framework. For each of these there is strong service user engagement in the decision making processes. For example, there has been a long standing Community Equipment Board to oversee the development and running of the service. This has always had strong user membership, again supported by an independent user support organisation. This in turn is supported by an equipment user reference group, which meets on its own and comments both on the day to day running of the service, as well as ambitions and aspirations. That group has identified the need to expand the service to 7 day working, as well as the work to develop a 'one stop shop' for equipment

services.

Similar, other strategic Boards have both individual representatives from the relevant service area; Carers, Homecare Users, MH service Users, people with Learning Disabilities etc. as well as representatives from User organisations such as Leeds Older People's Forum, Carers Leeds, and People First etc.

Others, such as the 'Better Lives Board' have a wider focus in regard to their areas of responsibility, but an even stronger user voice. The Better Lives Board is Chaired by the Lead Member for Adult Social care and is attended by senior ASC officers, but the majority of the membership are service users, recruited from a range of user groups in the city. Officers are summoned to the Board to outline any major service transformation or commissioning plans and the board acts as a form of service user scrutiny for these. The Board has also identified its own priority areas and ASC plans now need to reflect these. These have included identifying and deciding the Equality Markers within ASC. The Board has had presentations on the BCF and on particular schemes and their views on these have influenced the nature of the schemes. As these develop, this will be fed back into the Better Lives Board.

These Boards also engage with wider groups of service users, carers and wider community when looking to develop services further, such as the schemes in the BCF. This is done largely in partnership with organisations such as Leeds Involving People and Healthwatch Leeds and uses a variety of consultation methods, as outlined in the Homecare example above.

4. Citizen engagement

It is also important to hear the wider voice of citizens in Leeds, and also to ensure that work is led by that voice, not just 'us consulting with them'. There are a number of routes to do this, but at the heart now is the role of Healthwatch Leeds. They directly gather the views of service users, patients, carers and citizens as a whole and feed these into commissioning and service transformation. This includes directly into the Health and Well-Being Board but also by regular meetings with Commissioners where they can identify core issues they have picked up from their extensive consultations (events, questionnaire, Social Media, Meetings, their members/volunteers) and we can use these to inform our commissioning plans, in this case to assist in the prioritisation of the various submissions to the BCF.

It is also important to recognise that none of the above are one off processes. We continue to sustain and support engagement and a key element of the BCF plans will be to feedback to these groups, to ask them to take part in evaluation and to use this to develop work further

Appendix 2e

We are open seven days a week

We want to ensure that patients in the city are able to access **high quality and safe care** throughout the week. Responding to feedback from frontline professionals we have put together this brief guide. We want you to know about services that are available seven days a week that could help improve the patient pathway. In particular, this will mean safe transfers of care with appropriate services available to support patients moving from one care setting to another.

Primary care - extended access

The city's three clinical commissioning groups (CCGs) are working closely with their member practices so that we can improve access to primary care (GP) services in Leeds. There are already examples of patients being able to access early morning, late evening and weekend GP appointments, especially in the west of the city.

During periods of extreme system pressures we work with our primary care colleagues to offer extended access. This helps us to meet patient needs and help cope with additional demand on services, particularly within the acute setting.

Leeds Teaching Hospitals NHS Trust

As one of the largest hospital trusts in the country it is inevitable that we experience high levels of demand for acute services in Leeds. As a regional provider of a number of services there is an additional knock on effect to the pressures already experienced. A lot of work has been undertaken to help improve patient flow through the system. However demand is expected to continue to rise and work is ongoing to ensure we can respond to this pressure on services.

- All inpatient areas, accident and emergency department (AED) and treatment areas for urgent presentations are open out of hours and weekends. This includes diagnostic facilities and theatres
- Limited routine referral diagnostics open at weekends. Suggested patients and their families can be consulted if they want to be discharged on a Friday and return Monday as an outpatient for diagnostics - does occur now - but less routinely. Seven day diagnostics is a focus for the future
- Medicines reconciliation and pharmacy open weekends
- LTHT are making good progress in implementing seven day consultant review of patients. Consultant review occurs for majority of newly admitted patients at a weekend

Pharmacy department is open seven days providing medicine information, medicines reconciliation and supply services for inpatients. Call 0113 2065168, 9am - 7pm

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust offers a range of community services for adults and children from a range of settings including GP practices, clinics and patient's homes. Here are some services that offer seven day support.

Adults

SPUR (Single Point of Urgent Referral)
Available 8am to 6:00pm / Tel: 0113 376 0369

Neighbourhood Teams: 13 multi-disciplinary (citywide) teams aligned to GP practice populations. They work in a person's own home to provide:

- Nursing care for those unable to get to their GP practice
- Rapid response to prevent avoidable hospital admission
- Short term care to achieve earlier discharge from hospital
- Support to maintain independence
- Support at / approaching end of life

Available 7am to 10pm / Referral via SPUR

Night Nursing: To meet nursing and care needs overnight.
Available 10pm to 8:30am / Tel: 0345 6050621

Community Neurological Rehabilitation Service: Early supported discharge for people who have had a stroke, working closely with neighbourhood teams.
Available 8:30am to 4:30pm / Referral via SPUR

Joint Care Management Team: Assess and care manage Leeds residents (aged over 65) with complex health and social needs in hospital. Also care manage people (aged 18+) in hospital and the community, if registered with a Leeds GP and funded though NHS Continuing Healthcare (this includes those with Fast Track funding).
Referral via SPUR

Community Intermediate Care Beds: Intermediate rehabilitation support provided as a 'step up' from community or' step down' from acute settings. Offer 24 hour residential / nursing care based on patient need. Access to beds is managed via bed bureau. Tel: 0113 295 5220

Discharge Facilitators and Early Discharge Assessment Team (EDAT): Works with Leeds Teaching Hospitals NHS Trust (LTHT) to support discharge and prevent admission including support for people at the end of life.
Contact: LTHT ward staff

End of Life Care Home Facilitators: Additional support for patients at or near end of life in care home setting (residential and nursing).
Tel: 07736 480991 (08:30 to 16:30, seven days a week)

Community Intravenous Antibiotics Service (CIVAS) and Community Intravenous Diuretics Service
Tel: 0113 8431764 / 07960 727267 (08:30 to 16:30 on weekdays)

Children

Children's Nursing (CCN) Service: Provide high quality nursing care, short breaks and support in partnership with other professionals and agencies to children with a wide range of health problems. Some areas of the service cover seven days and there is some very specific 24/7 cover.
For further information contact: 0113 2728644 (office hours only)

Child and Adolescent Mental Health Services (CAMHS): We provide 24/7 inpatient services and occasional outreach service at weekends for vulnerable young people under 18.
Visit: www.leedscommunityhealthcare.nhs.uk for more information

Leeds and York Partnership NHS Foundation Trust

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides secondary mental health and learning disability services to people of Leeds and some specialist mental health services across the Yorkshire and Humber region. Visit www.leedsandyorkpft.nhs.uk for more information.

Crisis Assessment Service

LYPFT has a 24/7 Crisis Assessment Service providing a same day crisis response in the community where required. Referral and Advice line: 0300 300 1485

Acute Liaison Psychiatry

The acute laison psychiatry service (ALPS) offers 24/7 mental health assessments covering the emergency department and self-harm assessments on the acute hospital wards.

For LTHT staff contact the clinicians at any time please bleep through LYPFT switchboard on 0113 85 55000

Primary care - all enquiries from primary care should be directed to Liaison Psychiatry admin on tel: 0113 85 56730 / 56731 / 56762

Older People's Liaison Psychiatry Service

There is a dedicated older people's liaison psychiatry service that operates seven days a week, 9am-5pm. It provides mental health assessments in the emergency department and on acute wards. Staff can be contacted on 0113 206 7147

At weekends and on bank holidays the older people's service provides limited cover for urgent referrals. You can contact the team on: 07949 102129. Outside of these working hours all referrals for people 65 years and over will be directed to the ALPS service.

Medical Cover

LYPFT provide 24/7 medical cover. Outside of normal working hours this is through an on call rota and the on call psychiatrists can be contacted through LYPFT switchboard. Tel: 0113 85 55000

Leeds City Council Adult Social Care

For a number of patients additional support will be required through Leeds City Council's Adult Social Care. There are a range of services available to support the safe discharge of patients throughout the week, including the weekend. This is not restricted to care services but also Leeds Community Equipment Services.

Here's a list of services that could help you throughout the week:

- Leeds Community Equipment Services running 8am-6pm Monday to Friday and 8am-4pm on weekends
- Community support service for older people
- Assisted Living Leeds - joint with Leeds Community Healthcare NHS Trust
- Homecare Reablement Teams - 8am-10pm seven days a week (5pm-10pm is phone support only). Please note does not currently take new referrals at weekends
- Emergency duty team
- Domicillary care
- Telecare and mobile response works 24/7 (receive 300,000 calls a month)

Call 0113 222 4401, 9am - 5pm, Monday to Friday

Specialist Palliative Care

Specialist palliative care services are available in Leeds at St Gemma's Hospice, Wheatfields Hospice and Leeds Teaching Hospitals NHS Trust.

Both hospices offer an inpatient unit, day services and community services. Inpatient units at St Gemma's and Wheatfields are open 24/7, taking admissions on weekdays and also taking limited admissions at the weekend.

Specialist palliative care community nurses are available seven days of the week providing telephone and face to face advice and support for patients, families and professionals. This service operates from 8.30am to 5pm. There is a reduced weekend service provided by one clinical nurse specialist in each team.

Specialist palliative care clinical nurse specialists are available in the acute trust seven days of the week providing telephone and face to face advice and support for patients, families and professionals. This service operates from 8.30am to 5pm. At the weekend the service is provided by one clinical nurse specialist.

Advice is available outside these hours from the nurse in charge of the inpatient unit in each hospice for patients, families and professionals. A palliative medicine consultant is available to provide specialist medical advice - the rota and contact details are available via St James's University Hospital and hospice switchboards.

Wheatfields Hospice Therapy Team provides a seven day rapid response service.

For information about how to refer to any of these services, please phone the hospice.

Wheatfield Hospice Tel: 0113 2787249

St Gemma's Hospice Tel: 0113 2185500

Please note that the navigation bar & web links do not work in this version of the PDF

NHS

NHS Leeds Clinical Commissioning Groups
Leeds Integrated Dementia Board

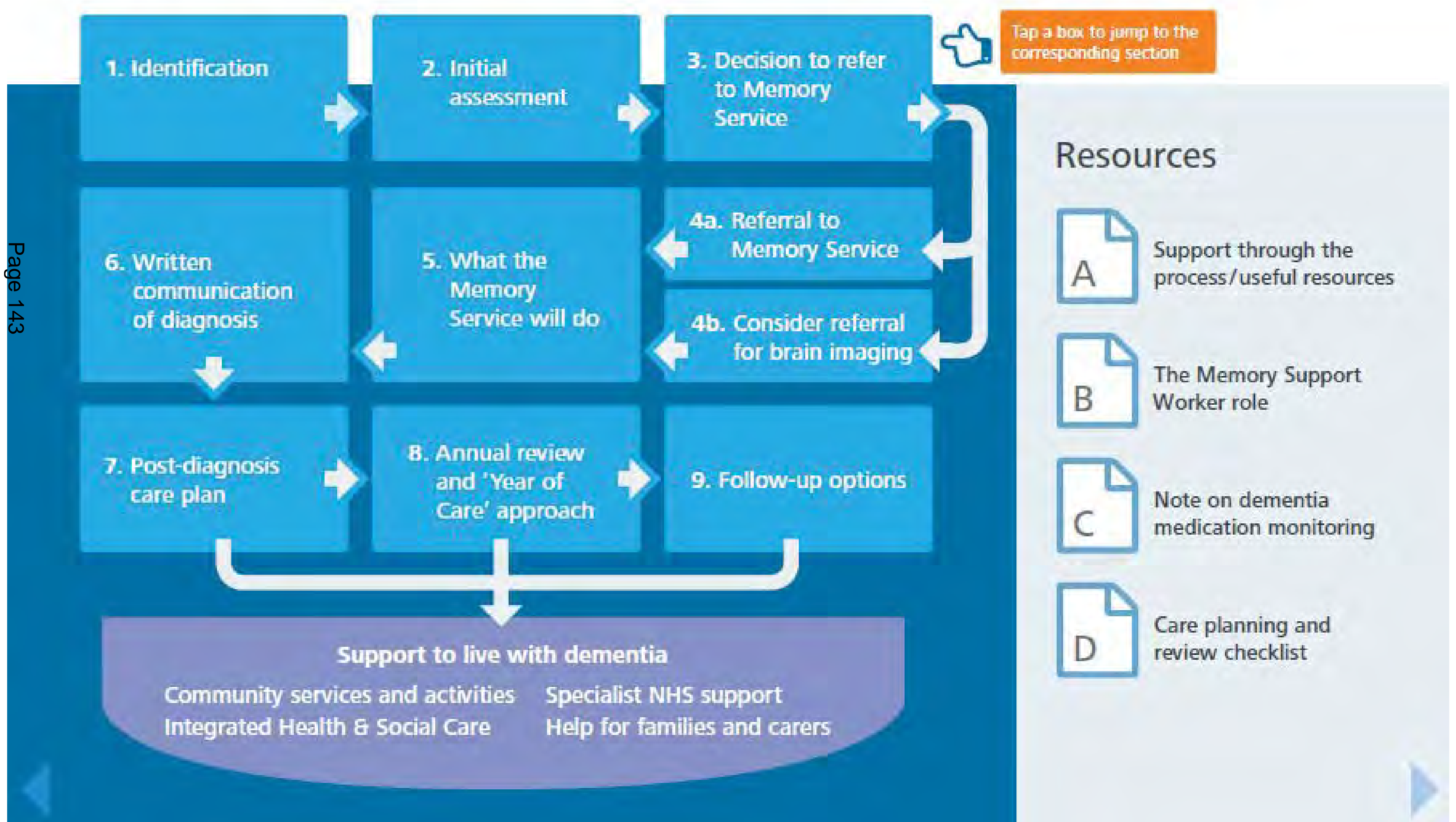
Dementia - timely diagnosis, care planning, and support for well-being. The pathway in Leeds

This document is a PDF optimised for viewing on a computer or tablet using Adobe Reader.

You can use the navigation bar across the top of the screen to jump directly to different sections, as well as using any web links to visit external resources.

Version: 1.0
Date: 5th February 2016

Dementia - timely diagnosis, care planning, and support for well-being. The pathway in Leeds



Support through the process

You can refer to Memory Support Worker for help before diagnosis

- people with memory problems who need practical or emotional support to access diagnosis
- the person is not ready or willing to seek diagnosis, but family/friends/carers may need help
- the person is seeking diagnosis, and support is needed whilst waiting

Useful resources

Awareness and understanding of dementia - for everyone

- 'Dementia Friends' awareness campaign
- NHS Choices: dementia diagnosis
- Alzheimers Society *'Worried About Your Memory?'*
- Alzheimers Society - 'Dementia Guide'

Local support and services - for everyone

- Living with dementia in Leeds - information page (see 'Documents' tab for useful leaflets)

Resources mainly for professionals

- e-learning package: Social Care Institute for Excellence - open dementia programme
- *'Worried About Your Memory'* poster and leaflet - eg. for clinics and surgeries
- Dementia Revealed: What primary care needs to know (NHS England, 2014)
- Helping you to assess cognition: A practical toolkit for clinicians (Alzheimers Society / NHS England / Royal Colleges - 2015)
- Leeds guideline for behavioural and psychological needs in dementia (2013)

1 Identification

People with memory problems and possible dementia are identified throughout the NHS and by awareness-raising initiatives:

- Patient and/or family may initiate concerns;
- Alzheimers Society *"Worried About Your Memory?"* campaign
- Awareness-raising in NHS Healthcheck (age 65-74)
- Screening in primary care long-term condition reviews (follow dementia DES)*
- Screening and assessment in acute hospital and community services*

*These screening processes include initial assessment & consideration of referral to memory service.

A Timely Diagnosis

"We should respect the decision of patients and families to present themselves at the time that is right for them. We can, gently and sensitively, nudge people towards thinking about their memory, but there is no justification for ambushing them."

What Is Normal ?

"It is normal to have occasional memory lapses and to lose things. It is normal to forget why we have gone upstairs, or to come back from a shopping trip without the very thing we went for. It is normal to have to search our brain for a name, sometimes.

"Our normal memory may suffer, from time to time, from impaired function through inattention, information overload or mild depression but, unless there is something wrong, we retain a huge store of general (semantic) knowledge, an ability to plan and manage our affairs and, under normal circumstances anyway, we retain our orientation in time and place."

from Dementia Revealed: What primary care needs to know (NHS England, 2014)

2 Initial assessment

- **History-taking from patient and family (or other 'informants') is the most important information,** supported by:
- Simple cognitive test (e.g. GP-COG / 6-CIT / AMTS - these are included on templates)
- Blood tests: FBC, calcium, glucose, renal and liver function, thyroid function, serum vitamin B12 and folate levels (for GP practices, these are identified in QOF DEM005).

Blood tests are to investigate potential reversible causes of cognitive problems. The decision to refer to Memory Service is usually made prior to results coming back. This is to avoid undue delay; Memory Service can see results on Leeds Care Record/ICE.

Consider:

- Depression screening and / or assessment of anxiety, if indicated. Depression and anxiety can be linked to dementia, or present with some similar symptoms. Seek specialist advice if required.

Tips

- on 'ICE' system, the blood tests can be ordered as a single group: from *Pathology Requesting* screen, click on *QOF Test Panels* and then select *Dementia*.
- if considering referral to Memory Service (steps **3** & **4**), and it seems that the patient might forget or miss appointments, ask if the person consents to arrangements being made directly on their behalf with family member/ carer, and communicate this consent to the Memory Service.
- **For people with a learning disability (intellectual disability):** symptoms of dementia can be very different, often presenting with changes in functional ability with or without behaviour change, and may require specialist assessment. If dementia is suspected, please seek advice from, or refer to, the specialists within the Community Learning Disabilities Team.

3 Decision to refer to Memory Service

Frail older people where presentation of dementia is clear and no other reason to refer - specialist referral may not be necessary. *"...patients who present with more advanced symptoms of dementia... may be diagnosed and managed in primary care..."* (Extract from RCGP & RCPsych guidance)

- GP can diagnose and record on practice system. The Diagnosing Advanced Dementia Mandate supports this, particularly for people in care homes.
- Refer to memory service if required eg. to consider prescribing; OR if management depends on diagnosis of sub-type.
- Consider for avoiding unplanned admissions, and/or referral to Memory Support Worker
- Consider Care Homes Liaison Service CMHT if needs and risks are complex.

Delirium may be slow to resolve eg. after acute infection/hospital admission, and make it hard to assess underlying cognitive impairment.

- Refer to Memory Service if cognitive decline preceded acute event;
- Monitor & review if cognition was normal prior to acute illness.
- Seek advice if required or history unclear - Memory Service or Community Geriatrician.

If history OR testing indicates cognitive impairment

- memory loss; difficulties with thinking, problem-solving or language;
- OR changes in behaviour, mood, personality, hallucinations not otherwise explained.
- OR if indicated by cognitive test score.

Offer referral to Memory Service

NB. if there are clear indications from history-taking, **do refer** - a 'normal' cognitive test score does not rule out dementia.

If there are support needs for the patient or family/carer whilst waiting to be seen by Memory Service, or if help is needed to eg. remember or attend appointments: involve Memory Support Worker and / or refer to other community services.

4a Referral to Memory Service

Include:

- Individual and family/social circumstances, history of concerns;
- Cognitive test scores;
- Medical history and current medication;
- Confirm that blood tests have been requested (p5), but do not await results if they are not yet available. Memory Service clinicians can view blood test and scan results on Leeds Care Record/ICE.
- **Consider referral for brain imaging (usually CT head scan) when referring to Memory Service (see step 4b).** This avoids serial waiting times which occur if memory service make the referral for a scan.
- If given, communicate consent for Memory Service to make arrangements directly with appropriate family member/carer.

Resources and notes:

- LYPFT referrals via Single Point of Access; other providers using local arrangements.
- Information for patients and families/carers: NHS Choices: dementia diagnosis
- Leeds now has Memory Clinics hosted at local GP practices - at least one for each old-age psychiatry consultant (LYPFT and TEWV). These offer more local options as an alternative to specialist hospital/outpatient locations.
- If support is needed whilst waiting; or people need practical or emotional support to access diagnosis: involve Memory Support Worker.

4b Consider referral for brain imaging

Refer for CT head scan at the same time as referring to Memory Service, to avoid serial waiting times. This is to inform the diagnosis, including type of dementia, and to exclude eg. injuries/tumours:

Unless

- current scan already available (e.g. carried out in hospital) OR;
- contra-indicated (e.g. frailty, declined by patient)

CT scans are quick to perform (1-2 minutes) and the large majority of patients tolerate it well.

Consider referral for MRI scan/consult with old-age psychiatrist for patients:

- with unusual or atypical presentations/acute or rapidly progressive dementia
- in the younger age group (generally < 65 years)

NB. MRI can be poorly tolerated by some patients. It takes 25 minutes to perform and the patient has to lie perfectly still in a tunnel with their head restricted within a helmet (the MRI coil). The scan produces an extremely loud noise which can be frightening and disorientating for the patient.

It is hoped to simplify CT scan requests for dementia diagnosis on the ICE system; in the meantime the following guidance is recommended:

"Scan reports are very dependent on the information provided by the requesting clinician. Key details about the patient should include: age, duration of memory problems, symptom progression, presence or absence of vascular disease … seek specific clarification on the presence of medial temporal lobe (hippocampal) atrophy, significant vascular ischaemic change and the presence of other intracranial pathology such as tumours.

An example request:

80 year old with 3-year history of short term memory difficulties. Vascular risk factors include history of hypertension. Need to clarify the presence of significant vascular ischaemic changes, medial temporal lobe atrophy (hippocampal atrophy) or space occupying lesion."

Guidance on Neuro-imaging in Dementia - Yorks & the Humber Strategic Clinical Network

5 What Memory Services will do

Memory assessment and diagnosis

- Further information-gathering from patient and family / carer
- Specialist cognitive testing (usually Addenbrooke's Cognitive Examination - ACE III)
- Review neuroimaging report (visible via Leeds Care Record for LYPFT)
- Consider further brain imaging
- Diagnosis (by old-age psychiatrist).

Immediate post-diagnosis

- Formulation of medical, psychological and social needs
- Initiate, review and titrate medication where appropriate
- As appropriate, offer of group or 1:1 nursing / OT / psychology interventions e.g. Memory Group, Cognitive Stimulation Therapy
- Offer "*Dementia Guide*" and "*Living With Dementia In Leeds*" leaflet, and other information according to individual needs and wishes
- Offer referral to Memory Support Worker.

6 Written communication after diagnosis

The Memory Service will

- write back to the referring GP on a standard letter format, including:
  - Diagnosis code in ICD, SystmOne and EMIS formats
  - Summary of prescribing , treatment, interventions
  - Recommendations for follow-up
- Copy to patient and carer, subject to informed consent.

This standard is agreed with LYPFT; GPs referring to other providers may receive similar information in a different format.

GP practice - on receipt of diagnosis letter

- Record diagnosis accurately, to ensure that the coding of dementia diagnosis will show on GP register (QOF - DEM001)

  GP practice admin staff should seek advice if correct coding is not clear.
- Continue with any recommended prescribing, as initiated and titrated in Memory Service
- Consider for avoiding unplanned admissions
- If 'Mild Cognitive Impairment' (MCI) is diagnosed, ensure this is flagged for review annually, or as recommended (unless Memory Service are reviewing). 10-15% of people diagnosed with MCI go on to develop dementia.

For any problems with coding dementia diagnoses on GP systems, please refer to NHS North Guidance on Dementia & Delirium Coding

B

The Memory Support Worker

This role was introduced in October 2015.
Memory Support Workers will:

- support people with memory problems to overcome practical and emotional barriers to seeking diagnosis, and / or families when the person is reluctant to seek diagnosis
- help people and carers connect to support if required during the diagnosis process
- offer a visit shortly after diagnosis; support to adapt to and live with dementia; inform about and connect to local services and networks
- screen for frailty and falls risk, and consider other physical health issues including those linked to avoidable hospital admissions
- be a named contact for the patient and family
- work closely with GP practices, including sharing care plans and follow-up from annual review.

Memory Support Workers, with the agreement of each GP practice, access GP practice systems (SystmOne, EMIS).

This makes it easy to take referrals as direct requests from practice teams; and to share information and care plans following interventions.

7 Post-diagnosis Care Plan

The Memory Support Worker will:

- complete a simple care plan document
- share it with patient and family/carer, and GP (subject to consent and capacity)
- check that care plan completion is recorded on GP dementia DES template
- check ethnicity coding is recorded and correct on GP system.

The Care Plan will include and share information about:

- physical, mental health and social needs and include referral/signposting to local support services
- where possible and through encouragement, include a recording of the patient's wishes for the future
- record discussion of permissions for the practice to speak directly with family/carers
- offer health check to carer(s)/inform carers' GP practice.

(This meets 'advanced care plan' requirement of the Dementia DES)

- prevention of unplanned hospital admissions. Leading causes for people with dementia are falls/fractures; respiratory, urinary and kidney infections
- names of family/friends trusted by the person to help and advocate; consider need for advocacy services
- communication needs and how to meet them eg. reminders about appointments; best approaches for conversations. (cf. NHS Accessible Information Standard).

8 Annual review and 'Year of Care' approach

Monitoring in primary care - the annual review (QOF DEM004)

- **Recommended: the Leeds 'Year of Care' approach** enables a 'whole-person' approach to how the person and family / carer are living with dementia alongside other long-term conditions
- This approach encourages and support people to decide goals and actions to achieve them
- The Year of Care review template is designed so that QOF annual review requirements can be checked off for each long-term condition
- Alternatively, a 'standalone' dementia review can be completed.

Many patients coming for review will not have a post-diagnosis care plan in place. Consider offering a referral to Memory Support Worker if a more in-depth conversation about living with dementia would be helpful.

Note on Memory Service involvement

- will continue active involvement with those patients with dementia, or with mild cognitive impairment, who require specialist biopsychosocial interventions (including those with associated behavioural and psychological symptoms of dementia and significant risk history)
- will no longer see patients solely for the purposes of routine medication monitoring
- will respond to requests for advice and re-referral when changes in need and risk are identified in primary care and elsewhere.

Note on dementia medication monitoring

The dementia drugs (Donepezil, Galatamine, Rivastigmine and Memantine) are now classified in Leeds as "Amber Level 2" – initiated by specialists, with little or no drug monitoring required.

- The main reported side effects for donepezil, rivastigmine and galantamine (the 'Cholinesterase Inhibitors') are loss of appetite, nausea, vomiting and diarrhoea. Other side effects may include muscle cramps, headaches, dizziness, fatigue and insomnia.
- The side effects of Memantine are less common and less severe. They include dizziness, headaches, tiredness, raised blood pressure and constipation.

Side effects of dementia medication usually occur early in treatment and are picked up by Memory Services during the initial stabilisation and review period. For concerns about possible side effects, seek advice from Memory Service.

Care Planning and Annual review - checklist

This checklist is to support clinical judgement; cover an item if it is relevant for the patient and carer.

- The review is essentially a helpful conversation with the person and family / carer, about how they are living with dementia, to agree goals and actions to achieve them.

Physical - consider:

- any problems with balance, falls risk, frailty; independent living / managing activities of daily living.
- whether medication being taken appropriately.
- prevention of unplanned hospital admissions. Leading causes of unplanned admissions for people with dementia are falls / fractures; respiratory infections; urinary and kidney infections

Consider for "2%" admission avoidance planning; community services as appropriate - eg. falls services, eating and drinking team, social worker, community matron, community geriatrician.

Psychological

- how is the person coping emotionally with the condition?
- changes to memory, mood, behaviour; concerns about boredom and frustration.

Consider seeking specialist advice / referring to Memory Service regarding risky or aggressive behaviours.

Social

- social life, activity and occupation.
- family and wider support networks.
- changes to communication needs.

Consider involving Memory Support Worker or social prescribing service

Carer / significant others

- How well is the carer coping? Are they getting a break from the caring role?

Consider carer support services (eg. Carers Leeds) - offer carer health check.

9 Annual review - options for follow-up

Any or all of the following may be appropriate, following annual review or at other times when changes or concerns come to light:

Concerns about

Social isolation, lack of networks, family/carer strain, need to discuss options and navigate the system, boredom.

Behavioural and psychological risks, consideration of dementia medication changes, concerns about side effects.

Other concerns about the progress of dementia, physical health, effects on independence/daily living/self-care.

Consider

- Memory Support Worker
- Carers Leeds
- Social Prescribing

These services can use their local knowledge of community support to identify the right help.

Refer to secondary mental health services:

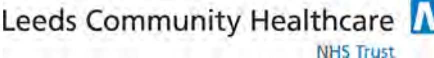
- Advice from, or referral back to, Memory Service
- Other specialist teams, eg. Care Homes Liaison, CMHT.

Options include:

- Integrated Neighbourhood Team, including social care needs assessment
- Community geriatrician
- Falls services
- Eating and drinking team
- End of life care.

The Leeds Teaching Hospitals NHS Trust

Leeds West Clinical Commissioning Group
Leeds North Clinical Commissioning Group
Leeds South and East Clinical Commissioning Group



Meeting Actions and Decisions

Meeting Title	Rapid Development Improvement Event Follow-up
Date	9th March 2016
Time	12:00-15:00
Location	Paul Sykes Seminar Room
Present	John Tatton (Chair), Carl Arnold, Cathy Bishop, Kathryn Adams, Diane Massey, Gill Warner, Emma Wright, Wendy Warriner, Daron Wray, Liz Watters, Vivien Lewis, Jenny Baines, Janet Fearnley, Peter Lower, Chris Roberts, Diane Boyne, Dawn Marshall, Melody Goldthorp, Tina Heath, Shona McFarlane, Gill Chapman, Joanne Adey

In Oct 2015 all partners in Leeds took part in a Trust Development Authority (TDA) sponsored Rapid Development Event focusing on improving processes from admission to discharge. Since event progress has been made in a number of key areas. A second follow up event took place on 9th March to review progress against a number of key areas. The following summarises the outcome of the event.

Topic	Decision & Actions Captured
Project 1: Referral for Supported Discharge Processes	This project focused on the redesign of referral process. This redesign had a number of key elements including 1) Agreement by all partners to a new referral pathway with agreed information protocols and agreed response times frames. These process changes, once fully embedded were aimed at speeding up processes and support improved reporting of reasons for referral delays 2) The new pathway was to be underpinned by a new electronic Request for Supported Discharge (RSD) form, which, went live on LTHT Electronic Patient Record System PPM+ on 21st January. The RSD process was the main area of focus for the workshop as this system has the highest degree of complexity and as such relies on shared partner ownership and engagement to ensure we act collectively to secure its success. Key areas discussed and action agreed are summarized below ***PPM+ Systems Issues****:* The event highlighted some on-going issues with the ways in which PPM+ form works (notably ability to send back electronically for more information). Also the ability to generate reports from the system. LTH fed back that an update of PPM+ will be in place by 23rd March to address some issues. However as of yet it is not clear how many of changes to system required will be able to be implemented. Action: LTH to share details of upgrade to partners once clear. Issues: There is clearly a limited resource available to support on-going development of PPM+ and conflicting priorities as to scheduling of developments. The fact that the PPM relies on a highly skilled in house development team (with limited resource) means that development lead times are limiting factors for this and potentially many flow projects that will rely on its development path.

	As a result we are creating manual reporting systems to get around the fact that PPM+ development capacity is limited. ***Quality of information from wards***: The group shared issues associated with variable information from wards. This was resulting in SPUR being required to request further details from wards to enable accurate allocation of cases to appropriate partners. Actions: • SPUR to provide report to LTH on: a) No. of SPUR requests for more information b) No. of SPUR escalations due to no response for information. • Nursing Leadership Team to use reports to spot patterns and focus on wards where information to SPUR is inadequate and where escalation had been required. • Report to be developed to track numbers of repeat information requests and escalations. ***System Process Response Times:*** The group discussed a range of issues associated with delivery of and tracking response times agreed within the original workshop. • *SPUR Allocation Response times*: It was agreed that where information was available and accurate that SPUR were allocating to parties within agreed timescales. • *Partner responses to SPUR Allocations*: The agreed process required that partners would **make contact with the ward** to agree timing for assessment/actions within 1 day of receiving SPUR allocation. Some agencies in the room had been monitoring e.g. Hospital Social Care and ICT, and believed they could evidence from local monitoring that they were meeting targets, but this monitoring was not systematic. Issue: There is a difficulty in systematically monitoring response times as information regarding cases sitting on different systems and there is no one point that tracks and can track. Ideally we will eventually develop PPM to enable tracking of referral and response (and to collect agreed next steps e.g. ICT to visit on X) to enable better coordination, but in the meantime we need to find a way for agencies to report that they have contacted wards on time. ***RSD and Notification of Discharge (NOD) on Same Day***: The group reflected that wards were sending both RSD and NOD's on the same day. This was felt to be inappropriate by the group and was resulting in a significant number of DTOCs being recorded as waiting for assessment (cat A) when they shouldn't be coded at all. LTH are endeavouring to address this through using information to assess cases where the dates for RSD and DTOC were same to reduce incidences. To ensure that DTOC figures were not reflecting the practice, the group agreed that a weekly audit would be undertaken of DTOC 'A' Codes (on Thursday) to ensure that the list was accurate and did not include cases that had not been initially assessed.

	Actions: • Operational Team to review DTOC list every Thursday to ensure national submission is accurate and reflects views of all partners as to validity. • Operational Team to report numbers of cases that are taken off list as results and track to see whether reducing. ***CHC Assessment:*** The new system has created some issues with the process for requesting CHC. Whereas the old system required every ward to fill in CHC checklist for every patient, the intention is that wards only complete where need has been agreed by appropriate professional. The key to identifying need was the quality of information provided at referral from the ward. It was agreed that rather than create work, the solution was to improve quality of referral information to ensure that SPUR can appropriately allocate cases. There was a further issue raised with regards to ability of ward staff to assess. Diane Boyne noted that there was now an online training package for nursing staff to support training in CHC checklist completion. Actions: • Wards to be supported to improve completion of information on RSD Form to ensure ease of identification of CHC type patients. • LTH to review how wards trained to support CHC Completion.
Project 2: Improvements in equipment ordering processes:	This project has been implemented successfully. New processes have now been implemented on key wards since 21st December to speed up the ordering of pressure relieving mattresses. The group heard how to date this had resulted in the ordering of 15 mattresses on the wards identified with no delays as a result to patients. Also the new processes had saved £4000 through ensuring appropriate allocation of mattresses. Actions: • Learning to be reviewed and process for bed ordering to be extended across all LTH wards. • Consideration of further equipment to be included at later stage.
Project 3: Electronic referrals to AHP:	Upgrades to PPM will eventually include dietician, physiotherapy and occupational therapy services for electronic referrals, which will speed up internal discharge processes. As of yet the system does not fully meet requirements which is leading to issues with tracking notably for OT where they are not ward based. Action: • Need to revisit timescale for PPM+ upgrades (see above re issues)

Project 4 – Systems Philosophy and Choice:	The original project identified that a large numbers of delays are as a result of patient and families not wishing to accept places offered in care homes or transitional beds whilst they wait for a care home of their choice. The group heard about latest developments: a) Leeds Teaching Hospitals have redesigned their pack 'My Home Planner', and all patients now receive this. b) LTH are putting up Home Planning posters on key wards to help patients understand why staying in Hospital is not the best choice. c) LTH are working with a designer to develop a magazine that will be available to patients to advertise their choices. There was discussion re the following: a) Differing views about the degree to which patients are really exercising choice within G code. View that many patients on choice are there with no viable offering i.e. EMI/ Dementia patients where funding has been approved but no home has been offered where home has accepted them. b) The need for update to choice letter to be progressed as latest version had not been signed off by CEOs. Once signed this will go into to the discharge planner. Actions: • Need to undertake a review of patients on choice list to ascertain reason for being on list as there is still a view among execs that the only reason they are there is that they will not accept offer of home. • Need to progress new letter at System Resilience Group (SRG).

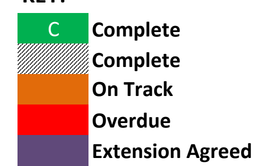
RAPID IMPROVEMENT WORKSHOP: 19th - 22nd October 2015

Executive Lead:
Project Owner:

Medical Lead:
Professional/Clinical Lead: **Dawn Marshall (Director of Nursing)**
Document Owner:
Project Team: Linzi Thakeray (Project Manager)

Start date: 03/09/15	Updated:

KEY:



Evidence Levels

Level 1 - document/policy generation
Level 2 - implementation/communication/roll-out
Level 3 - evaluation audit and testing

Referral for Support of Discharge

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	Divisional Exec Sign Off	STATUS	Week Beginning										
								19/10/2015	26/10/2015	02/11/2015	09/11/2015	16/11/2015	23/11/2015	30/11/2015	07/12/2015	14/12/2015	21/12/2015	28/12/2015
1	Agreed data collection							x										
2	Test form with staff from all agencies							x										
3	Pilot the form on J7 and J15 wards								x									
4	Collect feedback from all groups of staff and amend as required									x								
5	Add in data collection requirements to the form										x							
6	Ops group to plan for the roll out										x							
7	Comms sheet to all staff on the purpose of the form								x									
8	Agree which wards to pilot daily board rounds with social worker participation							x										
9	Pilot daily board rounds with social worker - J8 ward								x									
10	Collect feedback from from ward staff		PS						x									
11	Collect feedback from ward staff		VL						x									
12	Ops group to determine future role of this model and make recommendations to SRG									x								

Discharge Referral to District Nursing

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	Divisional Exec Sign Off	STATUS	Week Beginning										
								19/10/2015	26/10/2015	02/11/2015	09/11/2015	16/11/2015	23/11/2015	30/11/2015	07/12/2015	14/12/2015	21/12/2015	28/12/2015
1	Writing new district nurse forms. Agree upload to PPM.		VL/EW						x									
2	Create comms plans for all new processes.	DM	VL/EW						x									
	- new notifications																	
	- notifications of discharge																	
	- district nursing																	
	- board rounds																	
	- timeliness of referrals																	
	- OT referall/AHP referall via whiteboard																	
3	To agree and implement roles and responsibilities for LCH/LTHT band 6 discharge facilitators		VL/KA						x									
	- meet with band 6's and band 7 team leader									x								
	- Implement new roles									x								
	- agree feedback re-changes									x								

Electronic Notification of Referal within Adult Therapies

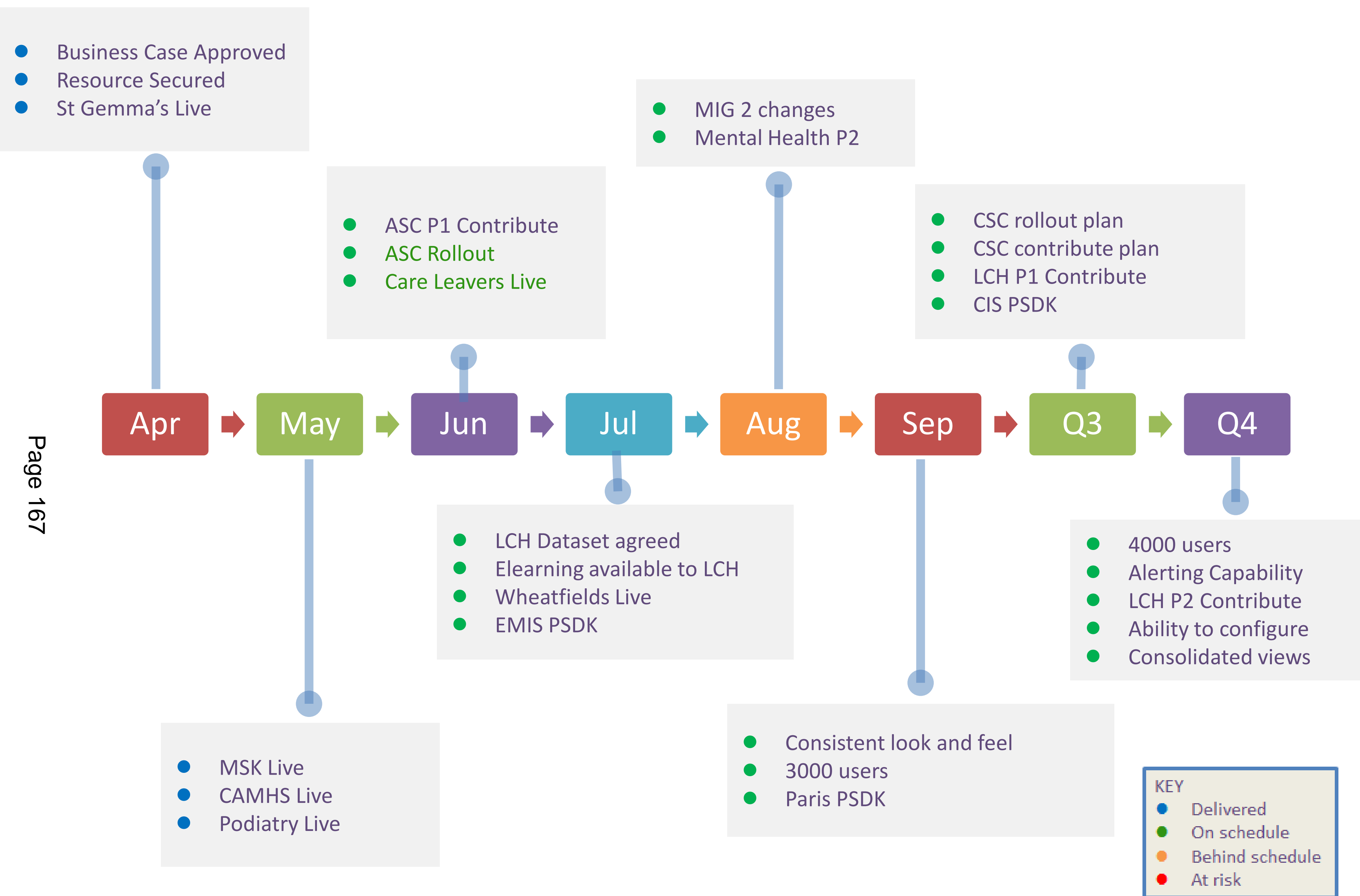
No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	Divisional Exec Sign Off	STATUS	Week Beginning										
								19/10/2015	26/10/2015	02/11/2015	09/11/2015	16/11/2015	23/11/2015	30/11/2015	07/12/2015	14/12/2015	21/12/2015	28/12/2015
1	New process for occupational therapy using PPM	J.H.	D.S.															
	IT Provide new format of PPM to include urgent referral																	
	IT provide individual review to identify new referrals																	
	IT provide free text box for OT and Physio																	
	IT provide activity report for referrals and response times.																	
	Inform and support OT staff with new notification process																	
	Inform users of change in referral process																	
	Provide support to wards and role out process																	
	Provide implement new process																	
	Review notification process at GPD of DAS OOG																	
	Review notification process at GPD of 6 weeks																	
	Following successful implementation with closure report																	
	Provide exception report for areas not using notification reporting																	
2	Adapt referral process within physiotherapy	P.L.	J.M.															
	IT Provide new format of PPM to include urgent referral																	
	IT provide individual review to identify new referrals																	
	IT provide free text to allow flow of information around physio																	
	IT provide activity/performance report for referrals and response times																	
	Ensure all physio staff (+OT) have access to PPM functions																	
	Roll out process change to physco staff and support change																	
	Review new notification report process at GPD of day 1																	
	Review notification report process at GPD of six weeks																	
	Provide support to ward staff with changes to process																	
	Identify other areas for																	
3	PPM notification process within adult therapies	PL/JH	J.B.															

Process for identifying appropriate pressure relief mattress for discharge - non stock

No	ACTION	Executive/Divisional OWNER	Operational Lead	Evidence Logged	Evidence Level	Divisional Exec Sign Off	STATUS	Week Beginning															
								19/10/2015	26/10/2015	02/11/2015	09/11/2015	16/11/2015	23/11/2015	30/11/2015	07/12/2015	14/12/2015	21/12/2015	28/12/2015	04/01/2016	11/01/2016	18/01/2016	25/01/2016	01/02/2016
1	Notification of referral for pressure reflief mattress via PPM (part of equip package)	TH	DS																				
2	Write process for identifying patient need for MMS glide mattress.								x														
3	Write process for identifying patient need for air flow mattress								x														
4	Sign off process and staff groups (LTHT)												x										
5	Sign off process and LCES-NS (LTHT) identified by LCES as assessors to order air flow mattress														x								
6	Identify and train trusted assessors (process and ordering system)															x							
7	Introduce new ordering process to ward and OT staff																x						
8	Monitor number of airflow mattresses issued																				x		
9	Review process																				x		
10	Sign off report - once successful																					x	

LCR Key Milestones – Basic Scope - Phase 4

Appendix 2h



7 Day services

The 7 Days a Week Forum, led by Sir Bruce Keogh, developed ten clinical standards describing the minimum level of service that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

The NHS England planning guidance for 2016/17 committed that 25% of the population should have access to high quality hospital care, seven days a week by 2017, 50% by 2018 and 100% by 2020 delivered by early implementer trusts that would be compliant with the 4 priority clinical standards identified as having the greatest impact upon mortality.

These are as follows:

Standard 2: Time to first consultant review

Standard 5: Access to diagnostics

Standard 6: Access to consultant-directed interventions

Standard 8: On-going review

A national baseline against the 4 priority clinical standards was undertaken in summer 2015, following which Leeds Teaching Hospitals NHS Trust was identified as an early implementer site along with 3 other trusts in West Yorkshire. Ongoing progress against delivery of the 4 priority clinical standards will be monitor via a twice yearly national survey.

Key objectives for LTHT in delivering 7 day services are as follows

- To improve patient outcomes and experience across the whole week and reduce variation which exists across weekdays and weekends
- To improve patient flow within the hospital such that safe and timely discharges are facilitated and length of stay is not negatively impacted upon
- To facilitate engagement across the whole workforce, with a particular emphasis upon the clinical workforce, in delivering improvements to patient care across the week.

As a provider of tertiary services across the West Yorkshire geography the trust is keen to support and facilitate a collaborative approach across the hospitals in West Yorkshire to delivering 7 day services.

These aspirations strongly link to the trust's values
Patient Centred
Fair
Collaborative
Accountable
Empowered

And to the over-arching goals expressed within the Trust's 5 year strategy
Seamless integrated care
Financially stable
Patient safety, quality and experience

- To date the following clinical areas have been prioritised for delivery:
- Acute and Elderly Medicine
- General Surgery
- Radiology and diagnostics

These areas were prioritised as being the high volume clinical pathways impacting upon the greatest number of patients.

Diagnostics has been prioritised as it supports timely decision making thereby not only improving the quality of patient care but also facilitating more timely flow through the system.

Early benefits :

- Strong organisational and clinical sign up to the delivery of 7 day services reflected in governance structure and ownership of the agenda at specialty level.
- Good progress against delivery of the 4 priority clinical – compliant with standard 5 and 6 and good level of progress against standard 2
- Reducing delays in non-elective in-patients

7DS Position

Trust: Leeds Teaching Hospitals Trust

Completed by: Susan Robins LWCCG

Standards in **bold** indicate those standards that the Academy of Medical Royal Colleges have been identified as having the most impact on reducing weekend mortality.

Standard	Summary Position	2016/17 Plan – key priorities
1	Families and carers are actively involved in decision making. Standard met 100%	To continue to deliver 100% compliance

7DS Position

Trust: Leeds Teaching Hospitals Trust

Completed by: Susan Robins LWCCG

Standards in **bold** indicate those standards that the Academy of Medical Royal Colleges have been identified as having the most impact on reducing weekend mortality.

Standard	Summary Position	2016/17 Plan – key priorities
2-Priority	**Time to consultant review.** Internal assessments show although some specialties are yet to be compliant in delivering specialist consultant assessment within 14 hours there is consistency across weekdays and weekends in terms of delivery against the standards. Routine ward rounds are delivered once daily to assess all new admissions and afternoon and evening reviews carried out by exception. More formal ward rounds have been introduced at weekends in general medicine and care of the elderly to increase compliance with the standard and to reduce variation in discharge rates at the weekend. Paediatrics have changed their working pattern and introduced a twilight shift for consultants. **The baseline showed compliance with all specialties except: General Surgery (70%), Respiratory Medicine (80%) and T&O (50%). NEWS is in place across the Trust in all specialties.** Current Rating : **RED**	

7DS Position

Trust: Leeds Teaching Hospitals Trust

Completed by: Susan Robins LWCCG

Standards in **bold** indicate those standards that the Academy of Medical Royal Colleges have been identified as having the most impact on reducing weekend mortality.

Standard	Summary Position	2016/17 Plan – key priorities
3	In-patients should be assessed for complex on-going needs within 14 hours by a multi-professional team. Standard met	
4	Handover must be lead by competent senior decision maker. Standard met.	

7DS Position

Trust: Leeds Teaching Hospitals Trust

Completed by: Susan Robins LWCCG

Standards in **bold** indicate those standards that the Academy of Medical Royal Colleges have been identified as having the most impact on reducing weekend mortality.

Standard	Summary Position	2016/17 Plan – key priorities
5-Priority	**Access to Diagnostics. CT scans are available 7 days a week.** Largely compliant only service not available at the weekend is histopathology. All specialties report they are in receipt of results/reporting within agreed timescales. Robust systems have been introduced to monitor and manage both demand and capacity to minimise delays to both access to testing and reporting. Current rating : **GREEN**	Priority MRI and echocardiography weekend provision Histopathology to be supported in 2016/17

7DS Position

Trust: Leeds Teaching Hospitals Trust

Completed by: Susan Robins LWCCG

Standards in **bold** indicate those standards that the Academy of Medical Royal Colleges have been identified as having the most impact on reducing weekend mortality.

Standard	Summary Position	2016/17 Plan – key priorities
6-Priority	**Access to consultant directed interventions. Access 7 days for critical care, Interventional radiology, Interventional endoscopy, emergency surgery, thrombolysis, PCI** All services available either on site or via networked approach. Access to PCI at the weekend has recently been introduced to compliment the PPCI service which was previously available. Current Rating :GREEN	Strengthen the Networked approach in place for highlighted services
7	Patients must be assessed by PL MH within appropriate timescales.	Further audit work to be completed

7DS Position

Trust: Leeds Teaching Hospitals Trust

Completed by: Susan Robins LWCCG

Standards in **bold** indicate those standards that the Academy of Medical Royal Colleges have been identified as having the most impact on reducing weekend mortality.

Standard	Summary Position	2016/17 Plan – key priorities
8-Priority	**On-going Review.** **All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily,** Presently compliant for twice daily review for Intensive Care and some areas of HDU (plan being developed) but not for SAU. MAU have 7 day consultant presence. Particular issues identified for patients who stay for very short period of time. Daily review not consistently available on base wards and although systems are in place for some specialties to identifying those patients who require daily review. Cardiology and respiratory have implemented twice daily ward rounds and care of the elderly have implemented daily ward rounds and a 4 pm board round. Current Rating : - **RED**	Service Units are currently reviewing provision against this standard following an initial audit and developing prioritised improvement plans.

7DS Position
Trust: Leeds Teaching Hospitals
Completed by: Susan Robins LWCCG

Standard	Summary Position	2016/17 Plan – key priorities
9	Support services should be available 7 days a week. Seven day pharmacy service in place providing both a dispensing and clinical service. Medicines reconciliation is available to all patients on admission with responsiveness at weekends improving. Physiotherapy and Occupational therapy are available for some patient groups on site 7 days a week and 7 day S< is available for stroke patients	Further audit work to be completed
10	Quality improvement	Audit and quality improvement are being integrated as part of Right care

7DS Position

LEEDS out if hospital 7 Day Services

Completed by: Susan Robins LWCCG

Service Area	Summary Position	2016/17 Plan – key priorities
7DS in Primary Care	Leeds West CCG has 22 / 37 GP Practices delivering core Primary care over 7 days. Leeds North and LSE CCG are reviewing their requirements. They work with GPOOH provider to provide 7DS over Bank Holidays.	Evaluation of Leeds west 7 Day primary care due Sep 2016. All CCG's will consider their plans for 7DS in Primary are in 2016
7DS in Community service provision	We have a 365 24/7 Community Health service that is provided at Neighbourhood level. We have joint referral / service access point to health and social care services via the Gateway. This works in a very integrated way with ASC social workers and the re ablement service that is provided 7 days. The BCF has invested to ensure the Leeds equipment Service is available 7 days per week which supports hospital discharge and enables more people to receive timely care in the community at weekends; avoiding unnecessary admissions. It has also enabled an increase of equipment being made available in peripheral stores and within the hospital as supply's can be maintained over the weekend; smoothing out the delivery and supply over 7 days. Investment in community beds also enabled the Community Bed Bureau to be available 7 days support access to community beds 365 days per year.	Development of NMC and integrated community nursing teams will be done over 7 days. Consideration of 7 days community respiratory teams. LCC Re ablement team to expand further in 2016 / 17 Further review of Intermediate care beds in 2016 / 17

Case study: Leeds – Developing an integrated community health and social care service

Leeds started developing its integrated community health and social care service in 2012. The service aims to provide high-quality, person-centred, co-ordinated care for people with long-term conditions, older people and carers. It works in partnership with individuals to promote health, independence and wellbeing.

Key elements in the service are:

- Single point of access – the service is accessed through a gateway which provides triage to ensure people go straight to the right place
- Integrated neighbourhood teams – 13 teams work alongside GP practices to support practice populations. These bring together previously separate services to provide integrated case management, community nursing and community therapy; each team also has community geriatrician input
- Integrated independent living team – providing step-up and step-down reablement and rehabilitation to reduce the need for hospital admissions and care home placements, and help people return home from hospital safely
- Access to digital, shared information – Leeds Digital Care Record is in place across much of Leeds NHS, and is set to be rolled out to social care

Case management is a crucial element of the model. An appropriate professional from the neighbourhood team is identified to proactively co-ordinate care and support identified through working with the individual and their family. Case managers, working with other professionals, ensure that personal plans and goals are set on the basis of needs, preference and individual choice. To date over 1,000 service users have been supported successfully through case management.

It was recognised early in the integration process that much more needed to be done than ‘lifting and shifting’ previously separate teams and professions and expecting them to work seamlessly together. A programme of support was instigated to establish a ‘one team’ approach and to develop the model over time, based on learning. This programme included:

- Workforce redesign and development
- A baseline survey of staff, service user and carer perceptions of integrated services, undertaken by Birmingham University and the Social Care Institute for Excellence
- Setting up a case management outcomes framework

Ensuring that people who use services and carers are at the heart of service delivery is vital. Building on the baseline survey, Leeds University National Institute for Health Research has worked with Leeds to develop a way of capturing how service users and carers experience integrated neighbourhood teams, so their views can be used to drive improvements.

The Service User Feedback Framework for Improving Integrated Care – SUFFICE – has been produced. Key features include:

- National Voices methodology – using 'I' statements, from the perspective of the service user
- A simple schedule for interviewing service users
- Training for people undertaking the interviews (in the trial, 15 people were recruited from Leeds' older people's networks)
- A mechanism for producing composite stories from the data
- A protocol to enable teams to listen to a composite story, understand their contribution to the story, select areas for service improvement, and develop a service improvement plan

When trialling the framework, Leeds University found that the process helped teams to focus both on the things they did well and on areas in which they could improve. Sometimes, however, teams moved away from the service user story and began to focus on organisational and professional issues.

The SUFFICE project report highlights a number of observations and recommendations about implementing the framework and was shared with other Pioneer sites at a learning event. It can be found at the following link: http://medhealth.leeds.ac.uk/info/555/research/746/integrated_health_and_social_care_teams_designing_a_developmental_evaluation_framework

Health and social care partners across Leeds are currently working together on how best to use the SUFFICE framework so that it compliments integrated care and its ongoing development.

Contact: Tricia Cable, NHS Leeds South and East CCG
Email:tricia.cable@nhs.net

Appendix 2

Cover

Q4 2015/16	
Health and Well Being Board	**Leeds**
completed by:	Tabitha Arulampalam
E-Mail:	tabithaarulampalam@nhs.net
Contact Number:	7702117388
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Rebecca Charlwood

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	16
4. I&E	19
5. Non-Elective Admissions	2
6. Supporting Metrics	9
7. Year End Feedback	16
8. New Integration Metrics	63
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board: Leeds

Question	Answer
Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Leeds

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	Yes	Yes	Yes	
4) In respect of data sharing - please confirm:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes	Yes	
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes	Yes	Yes	
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes	Yes	Yes	Yes	
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes	Yes	Yes	

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)

Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number

The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right
Local areas should:

- confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:

Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Leeds

Income

Previously returned data:

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

Q4 2015/16 Amended Data:

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

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	n/a

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,451,797	£6,451,797	£30,039,399	£11,980,007	£54,923,000	£54,923,000
	Forecast	£6,451,797	£6,451,797	£30,039,399	£11,980,007	£54,923,000	
	Actual*	£6,251,000	£6,451,797	£30,039,399			

Q4 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,451,797	£6,451,797	£30,039,399	£11,980,007	£54,923,000	£54,923,000
	Forecast	£6,451,797	£6,451,797	£30,039,399	£11,980,007	£54,923,000	
	Actual*	£6,251,000	£6,451,797	£30,039,399	£12,180,804	£54,923,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	n/a

Commentary on progress against financial plan:	n/a

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

Non-Elective Admissions

Selected Health and Well Being Board: Leeds

	Baseline				Plan					Actual				
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring. Please insert into Cell P8	17,681	17,399	17,278	18,145	17,310	16,883	16,583	17,259	16,765	17,158	17,437	17,365	19,227	21,097

Please provide comments around your full year NEA performance	e

Footnotes:
Source: For the Baselines and Plans which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs, as of 26th February 2016.

National and locally defined metrics

Selected Health and Well Being Board:	Leeds

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Provisional figures for Q4 show a higher proportion of people over 65's being admitted to permanent care home placements with 710 people per 100,000 over 65 population. This could be attributed to a change in the denominator figure reflecting population changes as well as recent counting in of self- funders.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Provisional figures for 2015/16 show an improved rate of people over 65 being successfully supported to remain at home following a hospital stay, 89% of those supported were still at home 3 months after leaving hospital.

Local performance metric as described in your approved BCF plan / Q1 / Q2 / Q3 return	Dementia Diagnosis Rate
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Leeds has met its target and is seeking improvements in other areas of dementia care

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	Individuals accessing health and social care services through integrated health and social care teams will be invited to complete the LTC6 questionaire post discharge. These questionaires will be used to generate a patient satisfaction score based on a wieghted average for all questions completed. There is a target in place to reach 50 completed questionaires per quarter for the service as a minimum.
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Completed LTC6 responses; Jan 16 - 60, Feb 16 - 92, Mar 16 - 71. LCH has a Quality Account action for 2016/17 to improve the response rate of patient satisfaction surveys (FFT & LTC6) It is anticipated that improvement in response rates will be evident at the end of Q2-4 2016/17.

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Year End Feedback on the Better Care Fund in 2015-16

Selected Health and Well Being Board: Leeds

Part 1: Delivery of the Better Care Fund		
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes		
Statement:	Response:	Comments: Please detail any further supporting information for each response
1. Our BCF schemes were implemented as planned in 2015-16	Agree	Some schemes were negatively impacted upon as a result of changes to the national tariff arrangements and the knock on effect this had on the local BCF allocation
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Agree	
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Disagree	The reasons for non-elective admission rates being higher than the plan could be partly attributed to activity outside of the control of the BCF programme. These are currently being investigated.
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Agree	
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Agree	
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Neither agree nor disagree	The rate of permanent admissions of older people to residential care has gone up in Q4; this could be attributed to a change in the denominator figure as well as counting in of self-funders.
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Agree	
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Agree	
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Agree	
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Agree	

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

11. What have been your greatest **successes** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **successes**	Response category:
Success 1	Building on partnership work across health and social care with commitment across agencies to follow this through into the STP programme	1.Leading and Managing successful better care implementation
Success 2	Safeguarding social care and 3rd sector service provision	2.Delivering excellent on the ground care centred around the individual
Success 3	Further development of IT systems across health and social care	3.Developing underpinning integrated datasets and information systems

12. What have been your greatest **challenges** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Alligning BCF expectations and strategic outcomes to pre existing service developments and the Leeds transformation programme	4.Aligning systems and sharing benefits and risks
Challenge 2	Lack of time to see some pilot projects through to full completion and lack of clarity of the strategic outcomes expected from some pilots.	5.Measuring success
Challenge 3	Understanding the reasoins behind the increase in no-elective-admission rates and the ability to reduce them	5.Measuring success

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

New Integration Metrics

Selected Health and Well Being Board: Leeds

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Not currently shared digitally
From Hospital	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Social Care	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Not currently shared digitally
From Community	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Not currently shared digitally
From Mental Health	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Shared via interim solution	Not currently shared digitally
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Unavailable	In development	In development	Unavailable	Unavailable	Unavailable
Projected 'go-live' date (dd/mm/yy)		31/03/17	31/03/17			

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot currently underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	82
Rate per 100,000 population	10

Number of new PHBs put in place during the quarter	6
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2016)	781,245

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

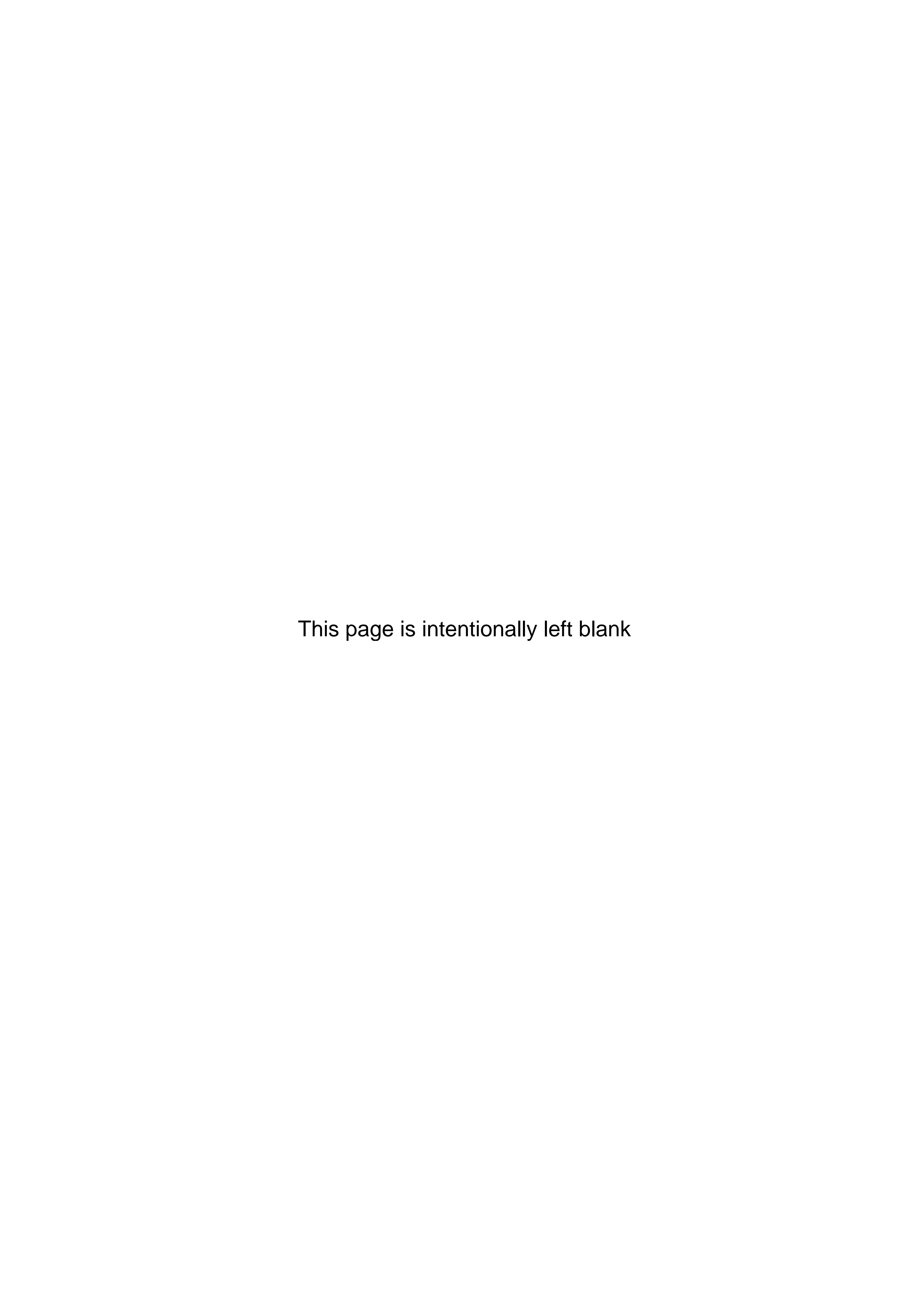
Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html
Q4 15/16 population figure has been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Leeds

Remaining Characters 29,258

Please provide a brief narrative on year-end overall progress, reflecting on the first full year of the BCF. Please also make reference to performance on any metrics that are not directly reported on within this template (i.e. DTOCs).
The BCF has helped sustain levels of service delivery during challenging times where the system has seen an increase in people with complex health needs accessing the NHS. This has driven cost up in non - elective admissions (NEA) which has meant we have not been able to meet our target on NEAs. However, because we have had a BCF programme in place it has helped to strengthen our out of hospital care sector which seems to have had a positive impact on other indicators relating to hospital admission. We have also sustained and improved implementing new ways of working across services that has had a positive impact on peoples live. Emergency admissions to hospital provide a proxy measure for the impact of these schemes on achieving the stated objected of reducing the need for hospital-based care. Whilst Leeds has not achieved its ambition of reducing all emergency admissions by 3.5% during 2015, this headline masks some notable improvements, particularly in relation to reducing the numbers of patients who stay in hospital one or more nights following an emergency admission (where admissions have seen a significant reduction of 0.03 admissions per 1,000 patients per week over the first three quarters of FY15/16) . Furthermore, Leeds has seen a reduction in the numbers of people accessing A&E services . These reductions are consistent with improvements in how the wider system is delivering out of hospital care. In line with BCF guidance, the Delayed Transfer of Care (DTOC) metric has been used as an indication of whether the plan for 2015/16 has delivered on this objective. Whilst bed days lost associated with DTOC increased during Q1 and Q2 of FY15/16, this deteriorating position can largely be attributed to improvements in the identification of patients who met the DTOC definition. This is consistent with total occupied bed day data, which demonstrates bed occupancy for emergency admissions to hospital has been remarkably stable for the last six years. Emergency admissions to hospital data indicates that for the last couple of years re-admissions have been approximately 11 patients per 1,000 population (for people who had 2 or more admissions in the previous 12 months). These represent the lowest rates for the past six years. Similarly, the numbers of people having two or more A&E attendances within a 28 day period has remained stable (at 1.8 patients per 1,000 population) for the past six years. Whilst these measures do not in themselves indicate what proportion of re-admissions might be avoided if out-of-hospital care were optimal, they provide assurance that efforts to discharge patients in a timely way has not negatively impacted re-admission or re-attendance rates. The proportion of people who receive reablement services following discharge from hospital and are still at home after 91 days post-discharge increased to 92% . This represents an improvement on last year's comparator and national average, and is deemed a good level of performance for the city.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