



HEALTH AND WELLBEING BOARD

**Meeting to be held in Headingley Enterprise & Arts (HEART) Centre,
Bennett Road, Leeds LS6 3HN on
Thursday, 28th September, 2017 at 10.00 am**

(with a pre-meeting for Board members at 9.30 am)

MEMBERSHIP

Councillors

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

Representatives of Clinical Commissioning Groups

Dr Jason Broch	NHS Leeds North CCG
Alistair Walling	NHS Leeds South and East CCG
Dr Gordon Sinclair	NHS Leeds West CCG

Nigel Gray	NHS Leeds North CCG
	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 Adults and Health
Steve Walker – Director of Children and Families

Representative of NHS (England)

Moirá 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

Safer Leeds Representative

Superintendent Sam Millar – West Yorkshire Police

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
2			WELCOME AND INTRODUCTIONS 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:-	

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 previous Health and Wellbeing Board meeting held 20th June 2017 as a correct record.

1 - 6

9

CONTINUING A CONVERSATION WITH CITIZENS: LEEDS HEALTH AND CARE PLAN

To consider the report of the Interim Executive Lead which provides an update on the Leeds Health and Care Plan and the continued conversation with citizens.

7 - 48

10		SYSTEM INTEGRATION - A BLUEPRINT FOR LEEDS To consider the report of the Chief Officer System Integration, Leeds CCG's Partnership. The Leeds Health and Wellbeing Strategy highlights the ambition to make sure that care is personalised and that more care is provided in people's own homes whilst making best use of collective resources to ensure sustainability. To achieve this, a blueprint has been developed with stakeholders to describe how commissioners and providers will move towards commissioning for population outcomes and integrated, jointly accountable provision.	49 - 134
11		LEEDS HEALTH AND CARE LOCAL SYSTEM DELIVERY PLAN 2017-18 To consider the report of Director of Commissioning, NHS Leeds CCGs, presenting an update on how Leeds will ensure system resilience to winter pressures in 2017-18.	135 - 156
12		LEEDS HEALTH AND CARE QUARTERLY FINANCIAL REPORTING To consider the report of the Leeds Health and Care Partnership Executive Group (PEG) which provides an overview of the financial positions of the health and care organisations in Leeds; brought together as one single citywide quarterly financial report.	157 - 164
13		INTEGRATED BETTER CARE FUND (IBCF) PLAN 2017-19 AND SPRING MONIES To consider the joint report of the Director of Commissioning, Strategy & Performance, NHS Leeds CCGs and LCC Chief Officer, Resources & Strategy, Adults & Health on the Better Care Fund 2017-19 submission, which was submitted to NHS England on 11th September 2017 and receive an update on the Spring Monies funding for information.	165 - 262

14		UNHEALTHY ATTITUDES - A 'ONE CITY' APPROACH FOR LEEDS To consider a report outlining the proposal to develop a one city approach to implementing the recommendations from Stonewall's "Unhealthy Attitudes" Report on the treatment of lesbian, gay, bisexual, transgender and gender & sexual minorities (LGBT+) people in Health and Social Care Services.	263 - 268
15		ANNUAL REFRESH OF THE FUTURE IN MIND:LEEDS LOCAL TRANSFORMATION PLAN FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING To consider the joint report of the Director of Commissioning NHS Leeds CCGs Partnership and LCC Director of Children & Families, on the refresh of the 'Future in Mind: Leeds Local Transformation Plan' which sets out the achievements to date and the next steps in the delivery of the vision and strategy. The report highlights the vision to develop a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with the skills to support those needs.	269 - 300
16		FOR INFORMATION: HEALTH PROTECTION BOARD ANNUAL REPORT To note receipt of the Health Protection Board Annual Report	301 - 326
17		ANY OTHER BUSINESS To note any other matters of business	
18		DATE AND TIME OF NEXT MEETING To note the date and time of the next formal meeting as Thursday 23rd November 2017 at 10.00 am (With a pre-meeting for Board Members at 9.30am) MAP OF VENUE	

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

TUESDAY, 20TH JUNE, 2017

PRESENT: Councillor R Charlwood in the Chair

Councillors D Coupar, B Flynn, S Golton,
and L Mulherin

Representatives of Clinical Commissioning Groups

Nigel Gray NHS Leeds North CCG

Directors of Leeds City Council

Dr Ian Cameron – Director of Public Health

Steve Hume – LCC Adults and Health

Sue Rumbold – LCC Children and Families

Representative of NHS (England)

Louise Auger - 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

Dean Royles - Leeds Teaching Hospitals NHS Trust

Thea Stein - Leeds Community Healthcare NHS Trust

1 Welcome and introductions

The Chair welcomed all present and brief introductions were made.

Additionally, Councillor Charlwood noted that Dr Alistair Walling had been appointed to represent NHS Leeds South and East Clinical Commissioning Group by Annual Council on 25th May 2017.

2 Appeals against refusal of inspection of documents

There were no appeals against the refusal of inspection of documents.

3 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

4 Late Items

No late of business were added to the agenda.

5 Declarations of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interests were made.

6 Apologies for Absence

Apologies for absence were received from Councillor G Latty, Gordon Sinclair, Phil Corrigan, Julian Hartley, Cath Roff, Steve Walker, Moira Dummer and Julian Hartley. The Board welcomed Councillor Flynn, Dean Royles, Steve Hume, Sue Rumbold and Louise Auger as substitutes to the meeting.

7 Open Forum

No matters were raised by members of the public under the Open Forum.

8 Minutes

RESOLVED – The minutes of the previous meeting held 20th April 2017 were agreed as a correct record.

9 Leeds Health and Care Plan: Progressing a conversation with citizens

The Board considered an overview of the emerging Leeds Health and Care Plan – Leeds’ description of what it envisaged health and care will look like in the future and how it will contribute to the delivery of the vision and objectives of the Leeds Health and Wellbeing Strategy 2016-21.

Paul Bollom, Interim Executive Lead for the Leeds Health and Care Plan, presented the report seeking support from the Board for the draft narrative of the Plan to be published in order to develop a citywide conversation with citizens. Stuart Barnes, NHS Leeds North CCG was also in attendance.

The draft narrative set the Leeds Plan in context with the West Yorkshire Sustainability and Transformation Plan. To achieve the maximum chance of engaging the public and delivering change; the Plan was user friendly and accessible reflecting the core value of working with the population. Discussion would be held alongside the wider future discussion on provision of public services – ‘changing Leeds’ discussions.

A copy of the draft ‘Leeds Health and Care Plan’ narrative document was attached as Appendix A along with a copy of the ‘Changing Leeds’ document at Appendix B

During discussions the following matters were raised:

- Acknowledged and welcomed the opportunity for the Community Committees to have had early discussions on the Leeds Plan during the Spring 2017. A request for an update to the community committees was noted
- The need to realise the value of the collective Leeds Pound and emphasise this within the health economy and beyond; acknowledging that service users may be buyers as well as consumers who could form co-operatives or social enterprises. This was also an opportunity to engage businesses in the ambitions of the Leeds Health and Care Plan; to interact with inclusive growth alongside Leeds Growth Strategy and with the Leeds Academic Health Partnership

- A request for the draft Plan to include a foreword emphasising the role of feedback in shaping a live document that will evolve. Associated to this, a review of the language and phrasing to ensure a plain English approach and to avoid inadvertently suggesting that areas of change have already been decided. The narrative to also clarify who will make decisions in the future
- The Plan to include case studies
- Acknowledged the need to broaden the scope of the Plan in order to *“if we do this, then this how good our health and care services could be”* and to provide more detail on what provision may look like in the future
- Noted the request for the Plan to provide more focus on some of the options from the Joint Health and Wellbeing Strategy
- References to taking self-responsibility for health should also include urgent care/out of hospital health
- References to the role of the Leeds Health and Wellbeing Board and the Joint Health and Wellbeing Strategy to be strengthened and appear earlier in the Plan
- Assurance was sought that the Plan would be co-produced as part of the ongoing conversation
- A focus on Leeds figures rather than national
- Requested that a follow up paper with more detail, including the extended primary care model, be brought back in September.

In conclusion, the Chair noted that the Board was supportive of the draft Plan being released for consultation, subject to the amendments suggested being made. Additionally, she expressed her support for the ‘plan on a page’ approach but noted that a decision needed to be made on whether to have a generic approach or provide specific information within the Plan i.e. detail had been provided on some health issues but not others such as Primary Care. In response, it was agreed that the SRO’s, the Interim Executive Lead for the Leeds Plan, a representative of Healthwatch and the Health Partnership Team would review the draft Plan narrative, including the ‘plain English’ request and report back to the Board in September 2017.

RESOLVED

- a) To note the contents of the report and the comments made during discussions;
- b) That having considered the draft narrative for the ‘Leeds Plan’, the feedback provided on whether it provides appropriate information to progress our conversation with citizens about the future of health and care in Leeds be noted.
- c) To note the intention for the SRO’s, the Interim Executive Lead, a representative of Healthwatch for the Leeds Plan and the Health Partnership Team to review the draft Plan narrative, including the ‘plain English’ request; and would report back to the Board in September 2017.

- d) To approve plans to progress a conversation with the public, based around the content of the summary report, and delivered in conjunction with the 'Changing Leeds' discussion.

10 Leeds Health and Care Quarterly Financial Reporting

The Board considered the report of the Leeds Health and Care Partnership Executive Group (PEG) which provided an overview of the financial positions of the health and care organisations in Leeds, brought together as one single citywide quarterly financial report.

The report provided a financial 'health check' to clarify where the current and expected financial pressures were in the local health and care system. This gave the Board an opportunity to direct action to support an appropriate and effective response as part of the Boards role in having strategic oversight of both the financial sustainability of the Leeds health and care system; and of the executive function carried out by the Leeds Health and Care Partnership Executive Group.

Bryan Machin, Chair of the Citywide Directors of Finance Group, presented the report. He highlighted key headlines from the report including:

- The Leeds health & care system ended 2016/17 in a more favourable position than that predicted at quarter 3.
- The plans for health and care services within Leeds City Council and for the Leeds CCGs demonstrated the delivery of a breakeven position across the future 4-year planning period. However, this was reliant on the assumed delivery of significant levels of recurrent savings and the CCGs being able to access some of their previously accumulated surpluses.
- The aggregate 4-year plans of the three NHS Trusts would not achieve breakeven across the whole period without receipt of additional national funding, better management of demand, and delivery of significant levels of savings.
- The significant financial risk associated with the plans of all partners and that further citywide action is required to mitigate the risks in single organisation plans.

A question was raised over whether budget sharing to further the 'one approach' to health and care would be supported by the Directors of Finance. It was noted that although this approach may be viewed favourably, consideration would have to be given to the evidence required to support this approach. Members recognised that statutory and regulatory responsibilities may impact on collaboration but felt that this approach should be explored.

Further discussions noted the continuing austerity measures and the challenge of finding money upfront to invest in collaborative working. Concern was expressed that CCGs may not be able to draw down any previously accumulated surplus funds, as suggested in the report, due to Treasury restrictions and national funding pressures. An approach to PEG was suggested in the first instance to consider the opportunities for collaboration and budget sharing.

RESOLVED –

- a) Having reviewed the Leeds health & care quarterly financial report, the Board noted its contents and the comments made during discussions;
- b) To note the extent of the financial challenge over the next year and until 2021 and the need to further develop a shared system-wide response and assurance that this challenge will be met;
- c) As part of the Boards' role to provide clear guidance to the Leeds Health and Care Partnership Executive Group on the possible actions required to achieve financial sustainability, the Board asked that PEG
 - i) Convene a workshop to consider and identify the opportunities for collaboration and budget sharing
 - ii) Undertake a piece of work to gather and understand savings and Return on Investment.

11 Being the Best City For Health Requires the Best Workforce

Tony Cooke, Chief Officer Health Partnerships Team, presented a report summarising the city's challenges relating to workforce and three potential and developing solutions. The Board was asked to consider it's' role in progressing, steering and directing future work to address the challenges, in the short term these were identified as:

- The impact of nursing bursaries (25% drop in applications)
- The impact of Brexit (96% fall in people coming to the UK to work)
- The number of health and care practitioners due to retire within the next 5 years (600,000)

The challenges ahead had highlighted the need to systematically "Grow your own workforce" with a focus on the establishment of a Health and Care Academy for Leeds, promotion of the living wage and supporting disabled people into employment.

Health & Care Academy – The Health and Social Care Academy would support a better targeting of employment opportunities in the city's more deprived areas. In answer to a query the Board received assurance that the Health Academy would focus on business as well as clinical skills, recognising the role of small and medium businesses in the health and care sector.

Work Related Long Term Illness - 32,000 people in Leeds received Employment & Support Allowance (ESA) - financial support for those who were unable to work through disability or illness. Of these, it was suggested that a large number had work related anxiety or musculoskeletal issues; and with the right support available to employers, that skilled and/or experienced workforce could be retained.

Dave Roberts, LCC Financial Inclusion Manager, provided the Board with information on the 'Living Wage', in particular:

- The influence the public sector had on the private sector
- 60% of children living in poverty are from working households
- The proven link between poverty and ill-health

Discussion followed on the proposal for public services to collaborate and develop a strategy to encourage momentum within the private sector for the Living Wage, noting a seminar had been proposed by the Integrated

Commissioning Executive (ICE) as an initial focus for the strategy. Comments included:

- Quality Care work – Paying appropriate wages will encourage staff retention, boost health and care outcomes and alleviate child poverty
- One approach to training - 57,000 people in Leeds work in the health and care sector and were largely trained within the organisation they work for. 'One approach' to training would encourage rotation throughout the health and care sector settings and break down barriers between the health and care settings in the public/private sector.
- The opportunities for joined up learning and training, recognising that there were issues across the public and private sectors which required the same training – such as moving/handling technique
- Awareness that many working in the health and care sector do so whilst they gain non-health and care related qualifications and/or language skills. Once complete, they often move out of the health and care sector
- The impact of the Apprenticeship Levy and whether this could be invested in health and care apprenticeships

RESOLVED -

- a) That, having considered the role of the Health and Wellbeing Board in overcoming challenges relating to workforce; the comments made during discussions be used to provide direction for progress towards the priorities of the Leeds Health and Wellbeing Strategy 2016-21.
- b) To support the engagement of members in discussions about the Living Wage and attend the Low Pay Seminar when arranged.
- c) To oversee/raise the profile of the Supporting Disabled People into Employment Project to ensure it remains consistent with the city's health and wellbeing priorities and participate in a 'health, wellbeing and employment workshop' in October 2017.
- d) To continue to note and support the development of Leeds Health and Social Care Academy and to receive regular updates on progress.
- e) To note that the City Workforce Work stream should be used to understand and plan responses to these challenges and keep the Board up to date with progress.

12 For information: Better Care Fund Quarterly Reports

Steve Hume, Chief Officer, Resources & Strategy (LCC Adults & Health) presented a report for information on the completed Better Care Fund (BCF) reporting templates for quarters 2, 3 and 4 for 2016-17. The report noted that a requirement of the BCF is that completed reporting templates are submitted quarterly to NHS England to provide assurance that the conditions of the BCF are being met.

RESOLVED – That the completed BCF reporting templates for quarters 2, 3 and 4 for 2016-17 be noted for information.

13 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next formal Board meeting as Thursday 28th September 2017 at 10.00am (with a pre-meeting for Board members at 9.30am).

Leeds Health and Wellbeing Board



Report author: Manraj Khela
(Programme Manager, Health Partnerships)

Report of: Paul Bollom (Interim Executive Lead, Leeds Health and Care Plan)

Report to: Leeds Health and Wellbeing Board

Date: 28 September 2017

Subject: Continuing a conversation with citizens: Leeds Health and Care Plan

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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
If relevant, access to information procedure rule number:		
Appendix number:		

Summary of main issues

1. The purpose of this paper is to provide Leeds Health and Wellbeing Board with an overview of the progress to date in shaping the Leeds Health and Care Plan (Appendix 1) following the previous meeting on 20 June 2017 and proposals to progress a conversation with the public, based around the content of the summary report, and delivered in conjunction with the 'Changing Leeds' discussion.
2. The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).
3. The Leeds Health and Care Plan is the city's approach to closing the three gaps that have been identified by health, care and civic leaders. These are gaps in health inequalities, quality of services and financial sustainability. It provides an opportunity for the city to shape the future direction of health and to transition towards a community focused approach, which understands that good health is a function of wider factors such as housing, employment, environment, family and community.
4. Perhaps most importantly, the Leeds Health and Care Plan provides the content for a conversation with citizens to help develop a person-centred approach to delivering

the desired health improvements for Leeds to be the Best City in the UK by 2030. It is also firmly rooted in the 'strong economy, compassionate city' approach.

Recommendations

The Health and Wellbeing Board is asked to:

- Endorse and support the consultation plans outlined in this paper to be undertaken on the draft narrative by officers with citizens and staff.

1 Purpose of this report

- 1.1 The purpose of this paper is to provide Leeds Health and Wellbeing Board with an overview of the progress to date in shaping the Leeds Health and Care Plan following the previous meeting and to seek support proposals to progress a conversation with the public.

2 Background information

- 2.1 The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).
- 2.2 The Leeds Health and Care Plan is the city's approach to closing the three gaps that have been identified by health, care and civic leaders. These are gaps in health inequalities, quality of services and financial sustainability. It provides an opportunity for the city to shape the future direction of health and to transition towards a community focused approach, which understands that good health is a function of wider factors such as housing, employment, environment, family and community.
- 2.3 Perhaps most importantly, the Leeds Health and Care Plan provides the content for a conversation with citizens to help develop a person-centred approach to delivering the desired health improvements for Leeds to be the Best City in the UK by 2030. It is firmly rooted in the 'strong economy, compassionate city' approach outlined in the Best Council Plan 2017-18.
- 2.4 The Leeds Health and Care Plan narrative sets out ideas about how we will improve health outcomes, care quality and financial sustainability of the health and care system in the city. The plan recognises the Leeds Health and Wellbeing Strategy 2016-2021, its vision and its outcomes, and begins to set out a plan to achieve its aims.
- 2.5 The Leeds Health and Wellbeing Board through 2016 has provided a strong steer to the shaping of the Leeds Health and Care Plan at formal board meetings on 12th January and 21st April 2016 and two workshops held on 21st June and 28th July 2016. The Board has held a further workshop on 20th April 2017 and a formal board meeting on 20th June 2017 where it reviewed and provided feedback on the draft narrative to support the plan.
- 2.6 The plan recognises and references the collaborative work done by partners across the region to develop the West Yorkshire and Harrogate Health and Care Partnership (formerly known as STP), but is primarily a Leeds based approach to transformation, building on the existing strategies that promote health and inclusive growth in the city. Whilst the financial challenge is a genuine one, the Leeds approach remains one based on long term planning including demand management, behaviour change and transition from expensive acute services

towards community based approaches that are both popular with residents and financially sustainable.

- 2.7 A transition towards a community focused model of health is outlined in the plan. This is the major change locally and will touch the lives of all people in Leeds. This 'new model of care' will bring services together in the community. GP practices, social care, third sector and public health services will be informally integrated in a 'primary care home'. Our hospitals will work closely with this model and care will be provided closer to home where possible, and as early as possible. New tools, known as 'Population Health Management' will be used to ensure the right people get the right services and that these are offered in a timely fashion. This is designed to prevent illness where possible and manage it in the community.
- 2.8 The Leeds Health and Care Plan narrative presents information for a public and wider staff audience about the plan in a way that that citizens and staff can relate to and which is accessible and understandable.
- 2.9 The Leeds Health and Care Plan narrative (when published) will be designed so that the visual style and branding is consistent with that of the Leeds Health and Wellbeing Strategy 2016-2021 and will be part of a suite of material used to engage citizens and staff with.

The narrative contains information about:

- The strengths of our city, including health and care
- The reasons we must change
- How the health and care system in Leeds works now
- How we are working with partners across West Yorkshire
- The role of citizens in Leeds
- What changes we are likely to see
- Next steps and how you can stay informed and involved

- 2.10 The final version will contain case studies which will be co-produced with citizen and staff groups that will describe their experience now and how this should look in the future.
- 2.11 It will enable us to engage people in a way that will encourage them to think more holistically about themselves, others and places rather than thinking about NHS or Leeds City Council services. Citizen and stakeholder engagement on the Leeds Health and Care Plan has already begun in the form of discussions with all 10 Community Committees across Leeds in February and March 2017.

3 Main issues

- 3.1 The development of the Leeds Health and Care Plan has been supported by partners and stakeholders from across various health and care providers and commissioners, as well as Healthwatch and Youthwatch Leeds, third sector and local area Community Committees. Conversations have also taken place over the last year about how best to align the citizen conversation about health and care in Leeds with 'Changing Leeds'.

- 3.2 The previous iteration of the Leeds Health and Care Plan was presented to the Leeds Health and Wellbeing Board on 20 June 2017. Using the feedback received the Leeds Health and Care Plan has been updated as outlined below:

Leeds Health and Wellbeing Board feedback (20 June 2017)	Action taken
Acknowledged and welcomed the opportunity for the Community Committees to have had early discussions on the Leeds Health and Care Plan during the Spring 2017. A request for an update to the community committees was noted.	The success of these sessions have been held up as a good practice example across the region of the value of working 'with' elected members and our local communities. We recognise that an ongoing conversation with elected members is key to this building on the sessions that took place. In addition to local ongoing conversations since Spring 2017, there are a number of engagement opportunities with elected members outlined throughout the report under para 3.6 including a second round of Community Committee discussions taking place during autumn/winter.
The need to emphasise the value of the Leeds Pound to the Health and Care sector and the need to acknowledge that parts of the health economy relied on service users not just as patients but buyers.	There is a greater emphasis to the Leeds Pound within the narrative document and it is now highlighted within the Leeds Health and Care Plan on a page through "Using our collective buying power to get the best value for our 'Leeds £'".
Emphasising the role of feedback in shaping the finished document.	The narrative in its introduction emphasises the engagement that has taken place to shape the document from conversations with patients, citizens, doctors, health leaders, voluntary groups and local elected members. The narrative also invites staff and citizens to provide feedback through various forums and mechanisms. Further work is needed to make this process easier and this will take place during October/November.
A review of the language and phrasing to ensure a plain English approach and to avoid inadvertently suggesting that areas of change have already been decided.	The narrative has been amended for plain English and emphasises the importance of ongoing engagement and co-production to shape the future direction of health and care in the city.
The narrative to also clarify who will make decisions in the future	The narrative makes greater reference to decision making in 'Chapter 10: What happens next?' highlighting that: • The planning of changes will be done in a much more joined up way through greater joint working between all partners involved with health and care partners, staff and citizens. • Significant decisions will be discussed and planned through the Health and Wellbeing Board. • Decision making however will remain in the formal bodies that have legal responsibilities for services in each of the individual health and care organisations.
The Plan to include case studies. Acknowledged the need to broaden the scope of the Plan in order to "if we do this, then this how good our health and care services could be" and to provide more detail on what provision may look like in the future.	Case studies are being co-produced with citizens and staff groups which will describe their experience now and how this should look in the future. These will be incorporated in the future iteration of the Plan as well as used in engagement sessions with communities.

References to the role of the Leeds Health and Wellbeing Board and the Leeds Health and Wellbeing Strategy 2016-2021 to be strengthened and appear earlier in the Plan.	The narrative in its introduction and throughout the document emphasises the role of the Leeds Health and Wellbeing Board. It also articulates that the Leeds Health and Care Plan is a description of what health and care will look like in the future and that it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021.
References to taking self-responsibility for health should also include urgent care/out of hospital health	Narrative has been updated to reflect this. In addition, the engagement through the autumn will be joined up around Leeds Plan, plans for winter and urgent care.
Assurance was sought that the Plan would be co-produced as part of the ongoing conversation	Plans outlined in this paper for ongoing conversation and co-production during the autumn.
A focus on Leeds figures rather than national	Work is ongoing with finance and performance colleagues and will feed into the engagement through the autumn.
Requested that a follow up paper with more detail, including the extended primary care model, be brought back in September.	The narrative has a greater emphasis on the transition towards a community focused model of health and is highlighted on the Leeds Health and Care Plan on a Page. A separate update on the System Integration will be considered by the Board on 28 September 2017.

- 3.3 In order to progress the thinking and partnership working that has been done to help inform the Leeds Health and Care Plan to date, the next stage is to begin a broader conversation with citizens. The conversation we would like to have with citizens will be focussed on the ideas and general direction of travel outlined in the Leeds Health and Care Plan. It will ask citizens what they think about the plan and will invite them to comment and provide their thoughts.
- 3.4 Our preparation for delivering a conversation with citizens about plans for the future of health and care in Leeds will be reflective of the rich diversity of the city, and mindful of the need to engage with all communities. Any future changes in service provision arising from this work will be subject to equality impact assessments and plans will be developed for formal engagement and/or consultation in line with existing guidance and best practice.
- 3.5 Recently, the emerging Leeds Health and Care Plan has been discussed this year at:
- All 10 Community Committees (February-March)
 - Team Leeds (17th March)
 - Scrutiny Board (Adult Social Services, Public Health, NHS) (28th March)
 - Forum Central Health and Care Leaders Network (29th March)
 - Healthwatch (29th March & 29th June)
 - Scrutiny Board Working Group (Adult Social Services, Public Health, NHS) (9th May)
 - Youthwatch (13th June)
 - Leeds Older People's Forum (21st June)
 - Working Age Provider Forum (12th July)
 - CCG Patient Assurance Group (23rd August)

3.6 Over the coming months, engagement will occur through a number of mechanisms outlined below. Where engagements occur this will be through a partnership approach involve appropriate representation from across the health and care partnership.

- Staff engagement through briefings, newsletters, team meetings, etc
- *Member Development Session – October / November*
Member Development Sessions are open to all 99 elected members and are a valuable way of ensuring that they are fully briefed on issues through workshops/ information sessions so that they can be prepared to champion them when engaging with the public or through their various roles.

The session will be led by the Chair of the Leeds Health and Wellbeing Board, Chair of the GP Provider Forum and the SROs/Leads of the Leeds Health and Care work programmes.

- *Community Committees - November / December*
Representatives from the Partnership Executive Group, Health Partnerships Team, local GPs will attend each of the Community Committee meetings in keeping with previous commitments to re-visit Committees as work progresses. To ensure the success of these local conversations there will also be:
 - o A citywide session will be arranged for the Community Committee Champions for Health and Wellbeing.
 - o An update on the Leeds Health and Care Plan will be presented at the Community Committee Chairs Forum on 16 November 2017.
- *'Working Voices' engagement - November*
We will work with Voluntary Action Leeds to deliver a programme of engagement with working age adults, via the workplace.
- *13 public events across city - November*
Working with Leeds Involving People (LIP) we will deliver a series of events in each of the Neighbourhood Team areas for citizens to attend and find out more about the future of health and care in Leeds. These will be in the style of public exhibition events, with representation and information from each of the 'Programmes' within the Leeds Plan and some of the 'Enablers'. To maximise the benefit of these events, they will also promote messages and services linked to winter resilience and other health promotion / healthy living and wellbeing services.
- *Third Sector engagement events - November*
We will work with Forum Central Leeds and others to deliver a workshop(s) to encourage and facilitate participation and involvement from the third sector in Leeds in the discussion about the Leeds Plan and the future of health and care in the city.
- *'Engaging Voices' Focus Groups, targeted at Equalities Act 'protected Characteristic Groups' - November*

We will work with VAL to utilise the 'Engaging Voices' programme of Asset Based Engagement to ensure that we encourage participation and discussion from seldom heard communities and to consider views from people across the 'protected characteristic' groups under the Equalities Act.

- 3.7 Leeds City Council is launching “Changing Leeds”. Changing Leeds is an engagement with the whole city on issues arising from the changing ‘social contract’, civic enterprise, and the future role of the council and other public services. Conversations have also taken place over the last year about how best to align the citizen conversation about health and care in Leeds with ‘Changing Leeds’.
- 3.8 The overall purpose of ‘Changing Leeds’ is to help people who live, work and study in the city think differently about their relationship with local public services, and ultimately do things differently as well.
- 3.9 In order to progress the thinking and partnership working that has been done to help inform the Leeds Health and Care Plan to date, the next stage is to begin a broader conversation with citizens.
- 3.10 Case studies are being co-produced with citizens and staff groups which will describe their experience now and how this should look in the future. The conversation with citizens will then be focussed on the ideas and general direction of travel outlined in the Leeds Health and Care Plan and whether these are in line with the case studies. We will also invite them to comment and provide their views and opinions on what the specific changes need to occur that will deliver the desired outcomes. Where the work of the Leeds Health and Care Plan develops firm proposals for service changes, then, specific plans would be developed for formal engagement and/or consultation in line with the relevant partner(s) organisational governance and best practice. Any future changes in service provision arising from this work will be subject to an equality impact assessment.
- 3.11 The conversation with the public, workforce and elected members will also include the direction of travel in relation to accountable care and what citizens can do to prepare themselves for winter. The aim is to coordinate and join up as much of the messages across the health and care system.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 A key component of the development and delivery of the Leeds Health and Care Plan is ensuring consultation, engagement and hearing citizen voice. The approach to be taken has been outlined within para 3.5 and 3.6.

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 an equality impact assessment.
- 4.2.2 Consultations on the Leeds Health and Care Plan have included diverse localities and user groups including those with a disability.

4.3 Resources and value for money

- 4.3.1 The Joint Strategic Needs Assessment (JSNA) and the Leeds Health and Wellbeing Strategy 2016-2021 have been used to inform the development of the Leeds Health and Care Plan. The Leeds Health and Wellbeing Strategy 2016-2021 remains the primary document that describes how we improve health in Leeds. It is rooted in an understanding that good health is generated by factors such as economic growth, social mobility, housing, income, parenting, family and community. This paper outlines how the emerging Plan will deliver significant parts of the Leeds Health and Wellbeing Strategy 2016-2021 as they relate to health and care services and access to these services.
- 4.3.2 The Leeds Health and Care Plan will directly contribute towards achieving the breakthrough projects: 'Early intervention and reducing health inequalities' and 'Making Leeds the best place to grow old in'.
- 4.3.3 The Leeds Health and Care Plan will also contribute to achieving the following Best Council Plan Priorities: 'Supporting children to have the best start in life'; 'preventing people dying early'; 'promoting physical activity'; 'building capacity for individuals to withstand or recover from illness', and 'supporting healthy ageing'.

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 Failure to have robust plans in place to address the gaps identified as part of the Leeds Health and Care Plan development will impact the sustainability of the health and care in the city.
- 4.5.2 Two key overarching risks present themselves given the scale and proximity of the challenge and the size and complexity of both the West Yorkshire and Harrogate Health and Care Partnership footprint and Leeds itself.
- 4.5.3 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.
- 4.5.4 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.
- 4.5.5 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 developing and delivering a robust Leeds Health and Care Plan within an effective governance framework.

5 Conclusions

- 5.1 As partners across the city working with our thriving third sector 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. The Leeds Health and Care Plan has been improved through engagement with a wide range of stakeholders and will continue to develop through further conversations with citizens. 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.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Endorse and support the consultation plans outlined in this paper to be undertaken on the draft narrative by officers with citizens and staff.

7 Background documents

- 7.1 None.

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How does this help reduce health inequalities in Leeds?

The Leeds Health and Care Plan (Leeds Plan) is the city's collective plan for addressing the three gaps that have been identified by health, care and civic leaders. These are gaps in: health inequalities; quality; and, financial sustainability. The Leeds Plan builds on the vision and objectives of the Leeds Health and Wellbeing Strategy 2016-21, and begins to develop the thinking about how these will be achieved. The Leeds Plan will provide the content for a discussion with citizens to help progress the planning that will be required to develop a citizen-centred approach to delivering the changes required for Leeds to be the best city for health in 2030.

How does this help create a high quality health and care system?

See above

How does this help to have a financially sustainable health and care system?

See above

Future challenges or opportunities

Opportunity to undertake a wide ranging and open conversation with the public as part of the 'Changing Leeds' programme and other engagements. This will enable us to engage people in a way that encourages them to think more holistically about themselves, others and places rather than thinking just about NHS or Leeds City Council services in isolation.

The conversation will help to inform the next phase of changing, improving and implementing the Leeds Plan.

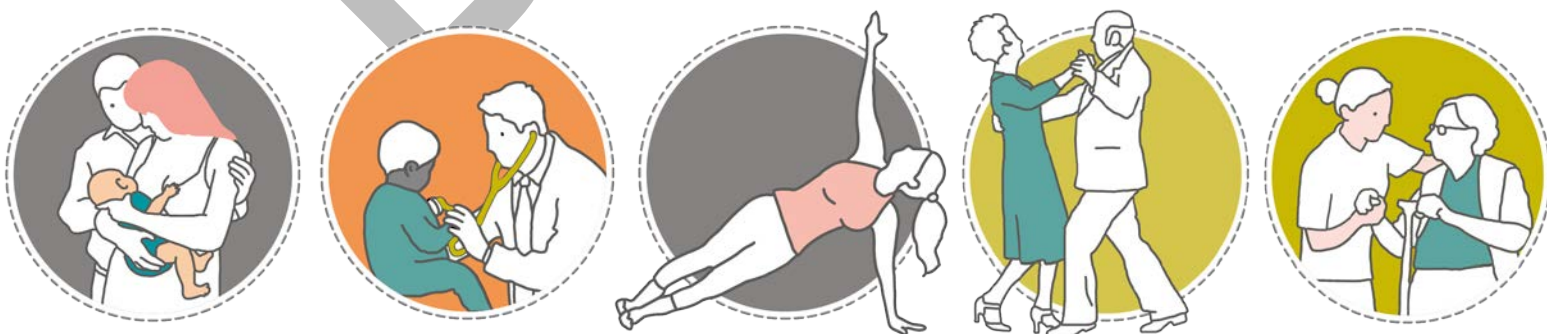
Priorities of the Leeds Health and Wellbeing Strategy 2016-21

A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X



Leeds

The best city for health and wellbeing



Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:

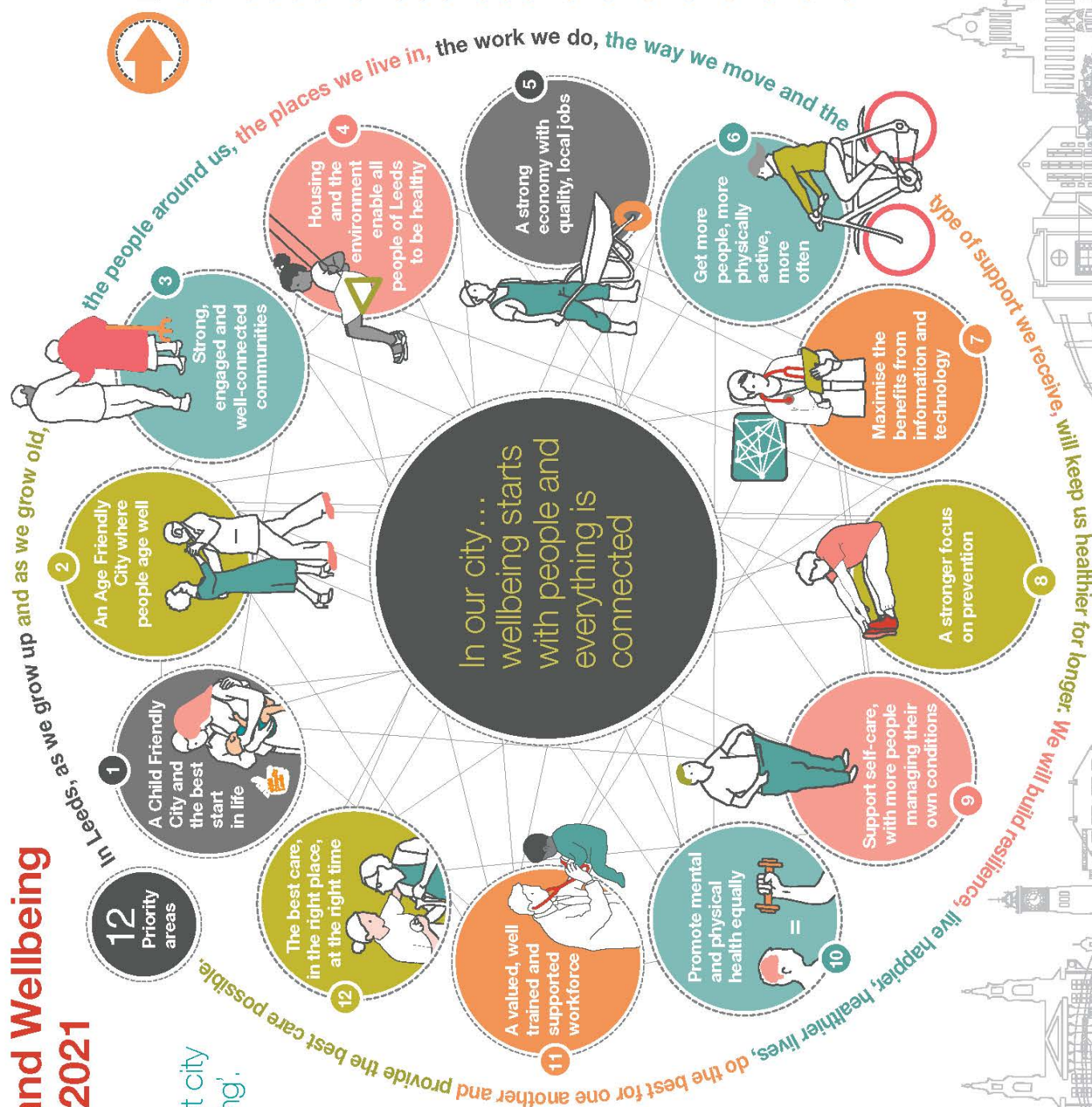
'Leeds will be the best city for health and wellbeing'.

And a clear vision:

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

5 Outcomes

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



Indicators

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

Leeds Health and Care Plan

By 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest

A plan that will improve health and wellbeing for all ages and for all of Leeds which will...

Protect the vulnerable and reduce inequalities

Improve quality and reduce inconsistency

Build a sustainable system within the reduced resources available

Our community health and care service providers, GPs, local authority, hospitals and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that...

Have citizens at the centre of all decisions and change the conversation around health and care

Build on the strengths in ourselves, our families and our community; working **with** people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong

Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens

Use neighbourhoods as a starting point to further integrate our social care, hospital and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis

Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do

Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire

What this means for me...	"Living a healthy life to keep myself well"	"Health and care services working with me in my community"	"Hospital care only when I need it"	"I get rapid help when needed to allow me to return to managing my own health in a planned way"
Key actions that will be undertaken... Please note that the actions are in the process of being refined.	- We will promote awareness and develop services to ensure the Best Start (conception to age 2) for every baby, with early identification and targeted support early in the life of the child. - We will promote the benefits of physical activity and improve the environments that encourage physical activity to become part of everyday life. - We will maximise every opportunity to reduce the harm from tobacco and alcohol, including enhancing the contribution by health and care staff. - We will have new accessible, integrated services that support people to live healthier lifestyles and promote emotional health and wellbeing for all ages, with a specific focus on those at high risk of developing respiratory, cardio-vascular conditions. - We will have a new, locally-based community service, 'Better Together', that can better build everyday resilience and skills in our most vulnerable populations.	- People living with severe breathing difficulties will know how to manage anxiety issues due to their illness and have a supportive plan about what's important to them by December 2017. - People living with severe frailty will be supported to live independently at home whenever possible, instead of having to go in and out of hospital. - People at high risk of developing diabetes and those living with diabetes will have access to support programmes to give them the confidence and skills to manage their condition by December 2017. - We will take the best examples where health and care services are working together outside of hospital and make them available across Leeds, for example muscle and joint services.	- Patients will stay the right time in hospital. - Patients with a mental health need will have their needs met in Leeds more often rather than being sent elsewhere to receive help. - We will meet more of patients' needs locally by ensuring their GPs can easily get advice from the right hospital specialist. - We will ensure that patients get the right tests for their conditions. - We will reduce the visits patients need to take to hospital before and after treatment. - We will ensure that patients get the best value medicines.	- We will review the ways that people currently access urgent health and social care services including the range of single points of access. The aim will be to make the system less confusing allowing a more timely and consistent response and when necessary appropriate referral into other services. - We will look at where and how people's needs are assessed and how emergency care planning is delivered (including end of life) with the aim to join up services, focus on the needs of people and where possible maintain their independence. - We will make sure that when people require urgent care, their journey through urgent care services is smooth and that services can respond to increases in demand as seen in winter. - We will change the way we organise services by connecting all urgent health and care services together to meet the mental, physical and social needs of people to help ensure people are using the right services at the right time.

Together these actions will deliver a new vision for community services and primary care in every neighbourhood. These will be supported by...

Working as if we are one organisation, growing our own workforce from our diverse communities, supported by leading and innovative workforce education, training and technology		Having the best connected city using digital technology to improve health and wellbeing in innovative ways
Using existing buildings more effectively, ensuring that they are right for the job	Using our collective buying power to get the best value for our 'Leeds £'	Making Leeds a centre for good growth becoming the place of choice in the UK to live, to study, for businesses to invest in, for people to come and work

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Chapter 1

Introduction

Leeds is a city that is growing and changing. As the city and its citizens change, so will the need of those who live here.

Leeds is an attractive place to live, over the next 25 years the number of people is predicted to grow by over 15 per cent. We also live longer in Leeds than ever before. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030. This is an incredible achievement but also means the city is going to need to provide more complex care for more people.

At the same time as the shift in the age of the population, more and more people (young and old) are developing long-term conditions such as #etes and other conditions related to lifestyle factors such as smoking, eating an unhealthy diet or being physically inactive.

Last year members of the Leeds Health and Wellbeing Board (leaders from health, care, the voluntary and community sector along and elected representatives of citizens in the city) set out the wide range of things we need to do to improve health and wellbeing in our city. This was presented in the [Leeds Health and Wellbeing Strategy 2016-2021](#).

The Leeds Health and Wellbeing strategy is required by government to set out how we will achieve the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. It is a requirement from government that local health and care services take account of our Strategy in their spending and plans for services.

Leaders from the city's health and care services, and members of the Health and Wellbeing Board now want to begin a conversation with citizens, businesses and communities about the improvement people want to see in the health and wellbeing of Leeds citizens, and ask if individuals and communities should take greater responsibility for our health and wellbeing and the health and wellbeing of those around us.

Improving the health of the city needs to happen alongside delivering more efficient, services to ensure financial sustainability and offer better value for tax payers.

The NHS in England has also said what it thinks needs to change for our health services when it presented the "Five Year Forward View for the NHS". As well as talking about the role of citizens in improving the health and wellbeing of Leeds, the city's Health and Wellbeing Board must also work with citizens to plan what health and care services need to do to meet these changes:

- Health and Wellbeing Board members believe that too often care is organised around single illnesses rather than all of an individual's needs and strengths and that this should change.
- Leaders from health and care also believe many people are treated in hospitals when being cared for in their own homes and communities would give better results.

"When the NHS was set up in 1948, half of us died before the age of 65.

Now, two thirds of the patients hospitals are looking after are over the age of 65.....life expectancy is going up by five hours a day"

Simon Stevens, Chief Executive NHS England

- Services can sometimes be hard to access and difficult to navigate. Leeds will make health and care services more person-centred, joined-up and focussed on prevention.

Improving the health of the city needs to happen alongside delivering better value for tax payers and more efficient services. This is a major challenge.

What is clear is that nationally and locally the cost of our health and care system is rising faster than the money we pay for health and care services. Rising costs are partly because of extra demand (such as greater numbers of older people with health needs) and partly because of the high costs of delivering modern treatments and medicines.

If the city carries on without making changes to the way it manages health and care services, it would be facing a financial gap. Adding up the difference each year between the money available and the money needed, by 2021 the total shortfall would be around £700 million across Leeds.

As residents, health care professionals, elected leaders, patients and carers, we all want to see the already high standards of care that we have achieved in our city further improved to meet the current and future needs of the population.

What is this document for?

We are publishing a Draft Leeds Health and Care Plan at a very early stage whilst ideas are developing. Ideas so far have been brought together from conversations with patients, citizens, doctors, health leaders, voluntary groups, local politicians, research and what has worked well in other areas. This gives everyone a start in thinking what changes may be helpful.

The Draft Leeds Health and Care Plan sets out initial ideas about how we could protect the vulnerable and reduce inequalities, improve care quality and reduce inconsistency and build a sustainable system with the reduced resources available. The key ideas are included at the front of this document; we want to help explain how we could make these changes happen.

This report contains a lot more information about the work of health and care professionals, your role as a citizen and the reasons for changing and improving the health and wellbeing of our city. Once you have taken a look we want to hear from you.

By starting a conversation together as people who live and work in Leeds we can begin creating the future of health and care services we want to see in the city.

We want you to consider the challenges and the plans for improving the health and wellbeing of everyone in Leeds. We want you to tell us what you think, so that together, we can make the changes that are needed to make Leeds the best city for health and wellbeing ensuring people are at the centre of all decisions.

Chapters 10 & 11 are where we set out what happens next, and includes information about how you can stay informed and involved with planning for a healthier Leeds.

Chapter 2

Working with you: the role of citizens and communities in Leeds

Working with people

We believe our approach must be to work 'with' people rather than doing things 'for' or 'to' them. This is based on the belief that this will get better results for all of us and be more productive.

This makes a lot of sense. We know that most of staying healthy is the things we do every day for ourselves or with others in our family or community. Even people with complex health needs might only see a health or care worker (such as a doctor, nurse or care worker) for a small percentage of the time, it's important that all of us, as individuals, have a good understanding of how to stay healthy when the doctor isn't around.

This is a common sense or natural approach that many of us take already but can we do more? We all need to understand how we can take the best care of ourselves and each other during times when we're at home, near to our friends, neighbours and loved ones.

Work health and care leaders have done together in Leeds has helped us to understand where we could be better.

What we need to do now is work with the people of Leeds to jointly figure out how best to make the changes needed to improve, and the roles we will all have in improving the health of the city.

The NHS Constitution

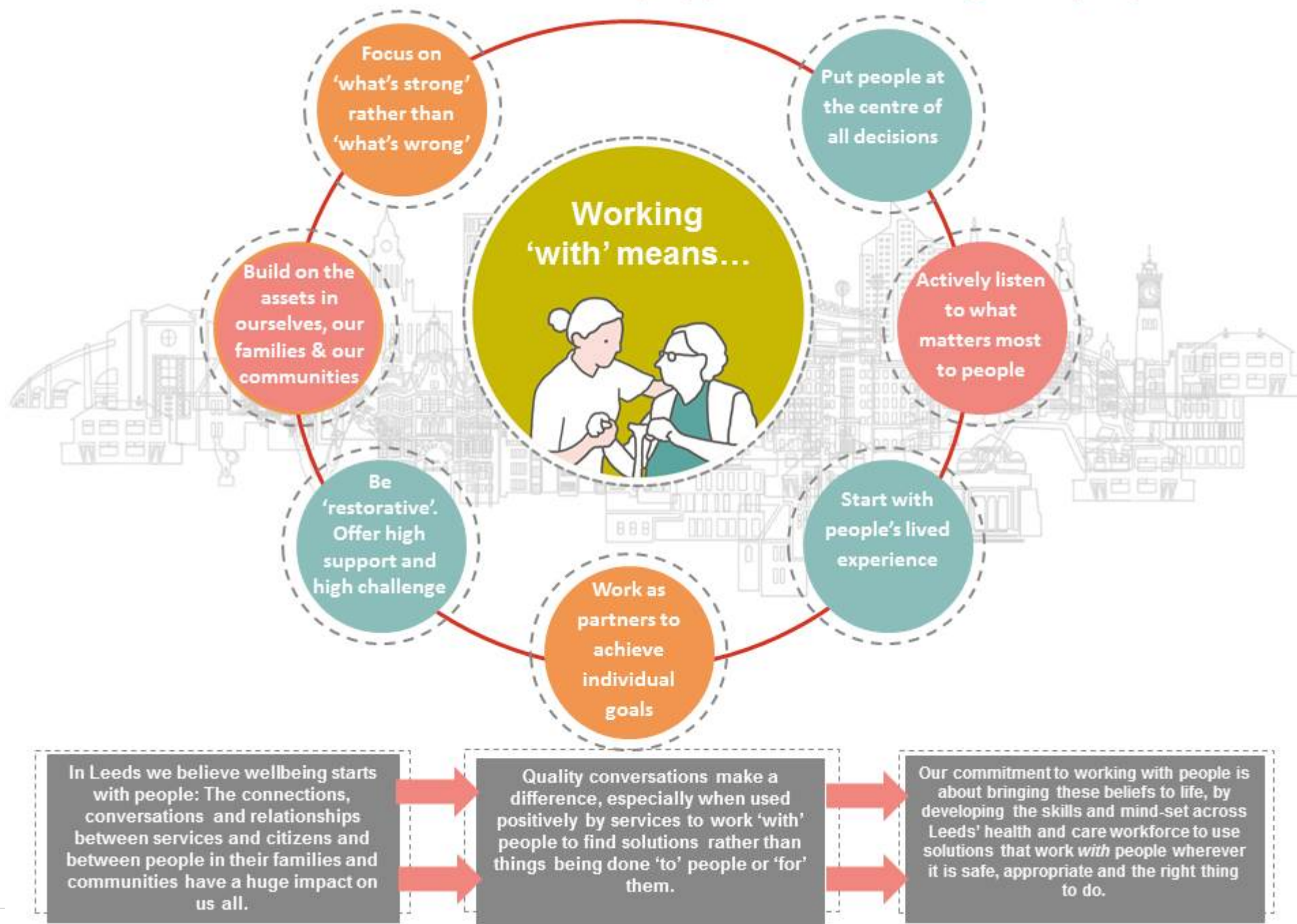
Patients and the public: our responsibilities

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Figure 1 on the next page, gives an indication of the new way in which health and care services will have better conversations with people and work with people.

Better conversations: A whole city approach to working with people



Joining things up

We all know good health for all of us is affected by the houses we live in, the air we breathe, the transport we use and the food that we eat. We know good health starts at birth and if we set good patterns early they continue for a life time. We know that physical and mental health are often closely linked and we need to treat them as one.

We need to recognise the connections between our environment and our health. This will mean ensuring that the physical environment, our employment and the community support around us are set up in a way that makes staying healthy the easiest thing to do.

It will mean working with teams in the city who are responsible for work targeted at children and families, planning and providing housing and the built environment, transport and others. It will also involve us working with charities, faith groups, volunteer organisations and businesses to look at what we can all do differently to make Leeds a healthier place in terms of physical, mental and social wellbeing.

Taking responsibility for our health

If we're going to achieve our ambition to be a healthier happier city, then each of us as citizens will have a role to play too.

In some cases this might mean taking simple steps to stay healthy, such as taking regular exercise, stopping smoking, reducing the amount of alcohol we drink and eating healthier food.

As well as doing more to prevent ill health, we will all be asked to do more to manage our own health better and, where it is safe and sensible to do so, for us all to provide more care for ourselves. These changes would mean that people working in health and care services would take more time to listen, to discuss things and to plan with you so that you know what steps you and your family might need to take to ensure that you are able to remain as healthy and happy as possible, even if living with an on-going condition or illness.

This wouldn't be something that would happen overnight, and would mean that all of us would need to be given the information, skills, advice and support to be able to better manage our own health when the doctor, nurse or care worker isn't around. By better managing our own health, it will help us all to live more independent and fulfilled lives, safe in the understanding that world class, advanced health and care services are there for us when required.

This won't be simple, and it doesn't mean that health and care professionals won't be there when we need them. Instead it's about empowering us all as people living in Leeds to live lives that are longer, healthier, more independent and happier.

Working together, as professionals and citizens we will develop an approach to health and wellbeing that is centred on individuals and helping people to live healthy and independent lives.

Cycling just 30 miles a week could reduce your risk of **cancer** by 45%

*That's the same as riding to work from **Headingley** to the **Railway Station** each day.*

Chapter 3

This is us: Leeds, a compassionate city with a strong economy

We are a city that is thriving economically and socially. We have the fastest growing city economy outside London with fast growing digital and technology industries.

Leeds City Council has been recognised as Council of the Year as part of an annual awards ceremony in which it competed with councils from across the country.

The NHS is a big part of our city, not only the hospitals we use but because lots of national bodies within the NHS have their home in Leeds, such as NHS England. We have one of Europe's largest teaching hospitals (Leeds Teaching Hospitals NHS Trust) which in 2016 was rated as good in a quality inspection. The NHS in the city provides strong services in the community and for those needing mental health services.

Leeds has a great history of successes in supporting communities and neighbourhoods to be more self-supporting of older adults and children, leading to better wellbeing for older citizens and children, whilst using resources wisely to ensure that help will always be there for those of us who cannot be supported by our community.

The city is developing innovative general practice (GP / family doctor) services that are among the best in the country. These innovative approaches include new partnerships and ways of organising community and hospital skills to be delivered in partnership with your local GPs and closer to your home. This is happening at the same time as patients are being given access to extended opening hours with areas of the city having GPs open 7 days per week.

Leeds is also the first major UK city where every GP, healthcare and social worker can electronically access the information they need about patients through a joined-up health and social care record for every patient registered with a Leeds GP.

We have three leading universities in Leeds, enabling us to work with academics to gain their expertise, help and support to improve the health of people in the city.

Leeds is the third largest city in the UK and home to several of the world's leading health technology and information companies who are carrying out research, development and manufacturing right here in the city. For example, we are working with companies like Samsung to test new 'assistive technologies' that will support citizens to stay active and to live independently and safely in their own homes.

The city is a hub for investment and innovation in using health data so we can better improve our health in a cost effective way. We are encouraging even more of this type of work in Leeds through a city-centre based "Innovation District".

Leeds has worked hard to achieve a thriving 'third sector', made up of charities, community, faith and volunteer groups offering support, advice, services and guidance to a diverse range of people and communities from all walks of life.

The Reginald Centre in Chapeltown is a good example of how health, care and other council services are able to work jointly, in one place for the benefit of improving community health and wellbeing.

The centre hosts exercise classes, a jobshop, access to education, various medical and dental services, a café, a bike library, and many standard council services such as housing and benefits advice.



Chapter 4

The Draft Leeds Health and Care Plan: what will change and how will it affect me?

Areas for change and improvement

To help the health and care leaders in Leeds to work better together on finding solutions to the city's challenges, they have identified four main priority areas of health and care on which to focus.

Prevention (“Living a healthy life to keep myself well”) – helping people to stay well and avoid illness and poor health.

Some illnesses can't be prevented but many can. We want to reduce avoidable illnesses caused by unhealthy lifestyles as far as possible by supporting citizens in Leeds to live healthier lives.

By continuing to promote the benefits of healthy lifestyles and reducing the harm done by tobacco and alcohol, we will keep people healthier and reduce the health inequalities that exist between different parts of the city.

Our support will go much further than just offering advice to people. We will focus on improving things in the areas of greatest need, often our most deprived communities, by providing practical support to people. The offer of support and services available will increase, and will include new services such as support to everyday skills in communities where people find it difficult to be physically active, eat well or manage their finances for example.

We will make links between healthcare professionals, people and services to make sure that everyone has access to healthy living support such as opportunities for support with taking part in physical activity.



Self-management (“Health and care services working with me in my community”) – providing help and support to

people who are ill, or those who have on-going conditions, to do as much as they have the skills and knowledge to look after themselves and manage their condition to remain healthy and independent while living normal lives at home with their loved ones.

People will be given more information, time and support from their GP (or family doctor) so

that they can plan their approach to caring for themselves and managing their condition, with particular support available to those who have on-going health conditions, and people living with frailty.

Making the best use of hospital care and facilities (“Hospital care only when I need it”)

– access to hospital treatment when we need it is an important and limited resource, with limited numbers of skilled staff and beds.

More care will be provided out of hospital, with greater support available in communities where there is particular need, such as additional clinics or other types of support for managing things like muscle or joint problems that don't really need to be looked at in hospital. Similarly there will be more testing, screening and post-surgery follow-up services made available locally to people, rather than them having to unnecessarily visit hospital for basic services as is often the case now.



Working together, we will ensure that people staying in hospital will be there only for as long as they need to be to receive help that only a hospital can provide.

Reducing the length of time people stay in hospital will mean that people can return to their homes and loved ones as soon as it is safe to do so, or that they are moved to other places of care sooner if that is what they need, rather than being stuck in hospitals unnecessarily.

Staff, beds, medicines and equipment will be used more efficiently to improve the quality of care that people receive and ensure that nothing is wasted.

Urgent and Emergency Care (“I get rapid help when needed to allow me to return to managing my own health in a planned way”) – making sure that people with an urgent health or care need are supported and seen by the right team of professionals, in the right place for them first time. It will be much easier for people to know what to do when they need help straight away.

Currently there are lots of options for people and it can be confusing for patients. As a result, not all patients are seen by the right medical professional in the right place.

For example, if a young child fell off their scooter and had a swollen wrist, what would you do? You could call your GP, dial 999 ring NHS111, drive to one of the two A&E units, visit the walk-in centre, drive to one of the two minor injuries units, visit your local pharmacy or even just care for them at home and see how they feel after having some rest, a bag of frozen peas and some Calpol.

Given the huge range of options and choices available, it's no wonder that people struggle to know what to do when they or their loved ones have an urgent care need.

We want to make this much simpler, and ensure that people know where to go and what to do so that they're always seen by the right people first time.

GP and Primary Care Changes

The biggest and most important idea to help with the above is to really change services to being more joined up around you – more integrated and more community focused.

The most important place to do this is in our communities and neighbourhoods themselves. It starts with recognising how communities can keep us healthy – through connecting us with activity, work, joining in with others and things that help gives us a sense of wellbeing. GPs, (primary care) nurses and other community services such as voluntary groups working closer as one team could focus better on keeping people healthy and managing their own health. We could also use health information better to target those at risk of getting ill and intervening earlier.

This will mean our whole experience of our local health service (or other community services such as a social worker) could change over time. We may find that in future we see different people at the GP to help us – for instance a nurse instead of a Doctor and we would have to spend less time travelling or talking to different services to get help. We may get more joined up help for housing, benefits and community activities through one conversation. It is likely that to do this GPs need to join some of their practices together to share resources, staff and premises to make sure they can work in this new way. Other health, care and community services will need to join in with the approach. We will all still be on our own GP list and have our own named doctor though – that will not change.

This big change would mean we would need to ensure we train our existing and future workforces to work with you in new ways. The approach would also use new technologies to help you look after your own wellbeing and help professionals to be more joined up.

The approach will bring much of the expertise of hospital doctors right into community services which would mean less referral to specialists and ensuring we do as much as we can in your community. This should mean fewer visits to hospital for fewer procedures.

Getting all of this right will help people be healthier and happier. It will mean we will further reduce duplication in the way that we spend money on care. Figure 2 shows how our use of the money available for health and care in Leeds might change. Note the shift towards more investment in Public Health where money will be used to encourage and support healthier lives for people in Leeds.

Where money is spent on health and care in Leeds, now and in the future

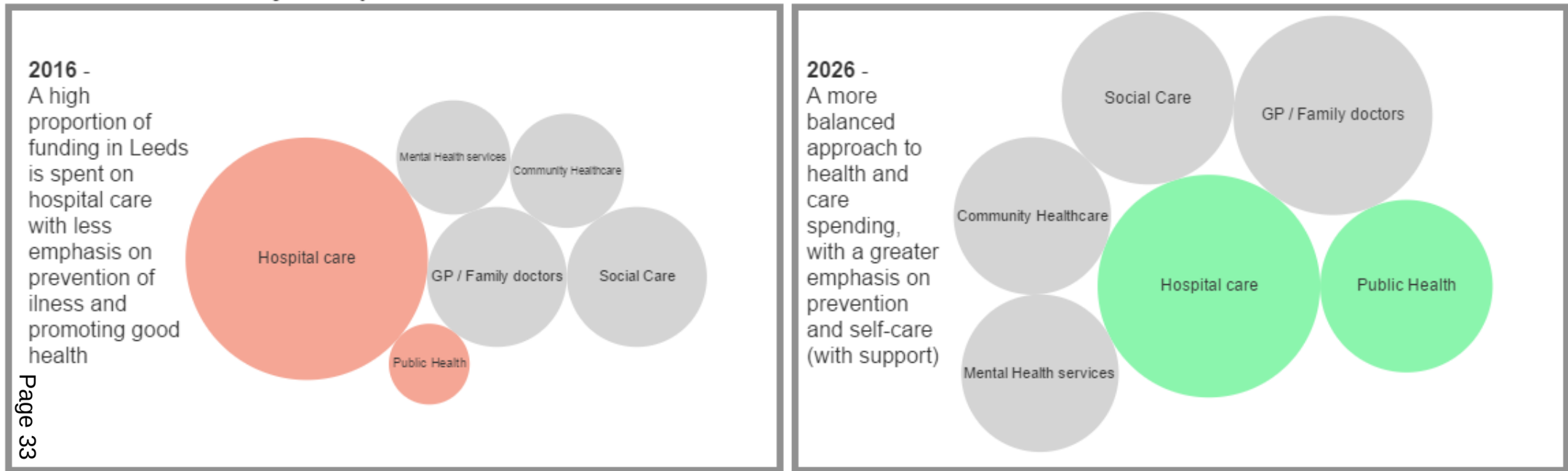


Figure 2 – An indicative view of the way that spending on the health and care system in Leeds may change

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Chapter 5

So why do we want change in Leeds?

Improving health and wellbeing

Most of us want the best health and care.

Most health and care services in Leeds are good. However, we want to make sure we are honest about where we can improve and like any other service or business, we have to look at how we can improve things with citizens.

Working together with the public, with professionals working in health and care and with the help of data about our health and our health and care organisations in the city, we have set out a list of things that could be done better and lead to better results for people living in Leeds.

This will mean improving the quality of services, and improving the way that existing health and care services work with each other, and the way that they work with individuals and communities.

We want to share our ideas with people in Leeds to find out whether citizens agree with the priorities in this plan. Citizens will be asked for their views and the information we receive will help us to improve the initial ideas we have and help us to focus on what is of greatest importance to the city and its people.

What we need to do now is work with people in the city to jointly figure out how best to make the changes and the roles we will all have in improving the health of the city.



Three gaps between the Leeds we have, and the Leeds we want

1. Reducing health inequalities (the difference between the health of one group of people compared with another)

- Reducing the number of early deaths from cancer and heart disease, both of which are higher in Leeds than the average in England
- Closing the life expectancy gap that exists between people in some parts of Leeds and the national average
- Reducing the numbers of people taking their own lives. The number of suicides is increasing in the city.

2. Improving the quality of health and care services in Leeds

- Improving the quality of mental health care, including how quickly people are able to access psychological therapy when they need it
- Improving the reported figures for patient satisfaction with health and care services
- Making access to urgent care services easier and quicker

- Reducing the number of people needing to go into hospital
- Reducing the number of people waiting in hospital after they've been told they're medically fit to leave hospital
- Ensuring that enough health and care staff can be recruited in Leeds, and that staff continue working in Leeds for longer (therefore making sure that health and care services are delivered by more experienced staff who understand the needs of the population)
- Improving people's access to services outside normal office hours.

3. Ensuring health and care services are affordable in the long-term

If we want the best value health services for the city then we need to question how our money can best be spent in the health and care system. Hospital care is expensive for each person treated compared to spending on health improvement and prevention. We need to make sure that we get the balance right to ensure we improve people's health in a much more cost effective way.

We believe the health and wellbeing of citizens in Leeds will be improved through more efficient services investing more thought, time, money and effort into preventing illness and helping people to manage on-going conditions themselves. This will help prevent more serious illnesses like those that result in expensive hospital treatment.

We think we can also save money by doing things differently. We will make better use of our buildings by sharing sites between health and care and releasing or redeveloping underused buildings. A good example of this is the Reginald Centre in Chapeltown.

Better joint working will need better, secure technology to ensure people get their health and care needs met. This might be through better advice or management of conditions remotely to ensure the time of health and care professionals is used effectively. For example having video consultations may allow a GP to consult with many elderly care home patients and their carers in a single afternoon rather than spending lots of time travelling to and from different parts of the city.

We plan to deliver better value services for tax payers in Leeds by making improvements to the way that we do things, preventing more illness, providing more early support, reducing the need for expensive hospital care and increasing efficiency.

Changing the way that we work to think more about the improvement of health, rather than just the treatment of illness, will also mean we support the city's economic growth - making the best use of every 'Leeds £'.

This will be important in the coming years, as failure to deliver services in a more cost effective way would mean that the difference between the money available and the money spent on health and care services in Leeds would be around £700 million.

Preventable **Diabetes**
costs taxpayers in Leeds
£11,700 every hour

This means if Leeds **does the right things now we will have a healthier city, better services and ensure we have sustainable services.** If we ignored the problem then longer term consequences could threaten:

- **A shortage of money and staff shortages**
- **Not enough hospital beds**
- **Longer waiting times to see specialists**
- **Longer waiting times for surgery**
- **Higher levels of cancelled surgeries**
- **Longer waiting times for GP appointments**
- **Longer waiting times in A&E**
- **Poorer outcomes for patients**



None of us wants these things to happen to services in Leeds which is why we're working now to plan and deliver the changes needed to improve the health of people in the city and ensure that we have the health and care services we need for the future.

This is why we are asking citizens of Leeds, along with people who work in health and care services and voluntary or community organisations in the city to help us redesign the way we can all plan to become a healthier city, with high quality support and services.

Chapter 6

How do health and care services work for you in Leeds now?

Our health and care service in Leeds are delivered by lots of different people and different organisations working together as a partnership. This partnership includes not only services controlled directly by the government, such as the NHS, but also services which are controlled by the city council, commercial and voluntary sector services.

The government, the Department of Health and the NHS

The department responsible for NHS spending is the Department of Health. Between the Department of Health and the Prime Minister there is a Secretary of State for Health. GPs were chosen by Government to manage NHS budgets because they're the people that see patients on a day-to-day basis and arguably have the greatest all-round understanding of what those patients need as many of the day to day decisions on NHS spending are made by GPs.

Who decides on health services in Leeds? The role of 'Commissioners'

About £72 billion of the NHS £120 billion budget is going to organisations called Clinical Commissioning Groups, or CCGs. They're made up of GPs, but there are also representatives from nursing, the public and hospital doctors.

The role of the CCGs in Leeds is to improve the health of the 800,000 people who live in the city. Part of the way they do it is by choosing and buying – or commissioning - services for people in Leeds.

They are responsible for making spending decisions for a budget of £1.2bn.

CCGs can commission services from hospitals, community health services, and the private and voluntary sectors. Leeds has a thriving third sector (voluntary, faith and community groups) and commissioners have been able to undertake huge amounts of work with communities by working with and commissioning services with the third sector.

As well as local Leeds commissioning organisations, the NHS has a nationwide body, NHS England, which commissions 'specialist services'. This helps ensure there is the right care for health conditions which affect a small number of people such as certain cancers, major injuries or inherited diseases.

Caring for patients – where is the health and care money spent on your behalf in Leeds?

Most of the money spent by the local NHS commissioners in Leeds, and by NHS England as part of their specialist commissioning for people in Leeds is used to buy services provided by four main organisations or types of 'providers', these include:

GPs (or family doctor) in Leeds

GPs are organised into groups of independent organisations working across Leeds. Most people are registered with a GP and they are the route through which most of us access help from the NHS.

Mental Health Services in Leeds

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides mental health and learning disability services to people in Leeds, including care for people living in the community and mental health hospital care.

Hospital in Leeds

Our hospitals are managed by an organisation called Leeds Teaching Hospitals NHS Trust which runs Leeds General Infirmary (the LGI), St James's Hospital and several smaller sites such as the hospitals in Wharfedale, Seacroft and Chapel Allerton.



Mental Health affects many people over their lifetime. It is estimated that 20% of all days of work lost are through mental health, and 1 in 6 adults is estimated to have a common mental health condition.

Providing health services in the community for residents in Leeds

There are lots of people in Leeds who need some support to keep them healthy, but who don't need to be seen by a GP or in one of the city's large hospitals such as the LGI or St James. For people in this situation Leeds Community Healthcare NHS Trust provides many community services to support them.

Services include the health visitor service for babies and young children, community nurse visits to some housebound patients who need dressings changed and many others.

Who else is involved in keeping Leeds healthy and caring for citizens?

As well as the money spent by local NHS commissioners, Leeds City Council also spends money on trying to prevent ill health, as well as providing care to people who aren't necessarily ill, but who need support to help them with day to day living.

Public health – keeping people well and preventing ill health

Public health, or how we keep the public healthy, is the responsibility of Leeds City Council working together with the NHS, Third Sector and other organisations with support and guidance from Public Health England.

Public Health and its partners ensure there are services that promote healthy eating, weight loss, immunisation, cancer screening and smoking cessation campaigns from Public Health England and national government.

Social care - supporting people who need help and support

Social care means help and support - both personal and practical - which can help people to lead fulfilled and independent lives as far as possible. Social care covers a wide range of services, and can include anything from help getting out of bed and washing, through to providing or commissioning residential care homes, day service and other services that support and maintain people's safety and dignity.

It also includes ensuring people's rights to independence and ensuring that choice and control over their own lives is maintained, protecting (or safeguarding) adults in the community and those in care services.

Adult social care also has responsibility for ensuring the provision of good quality care to meet the long-term and short-term needs



of people in the community, the provision of telecare, providing technology to support independent living, occupational therapy and equipment services.

Lots of questions have been asked about whether the government has given enough money for social care, and how it should be paid for.

During 2016/17 Leeds City Council paid for long term packages of support to around 11,000 people.

Approximately 4,230 assessments of new people were undertaken during the 2016/17 with around 81.5% or 3,446 of these being found to be eligible to receive help.

Leeds City Council commissions permanent care home placements to around 3,000 people at any time, and around 8,000 people are supported by Leeds Adult Social Care to continue living in their communities with on-going help from carers.

Figure 3, shows how the local decision makers (NHS Commissioners and Leeds City council) spend health and care funding on behalf of citizens in Leeds.

Amount (£m)

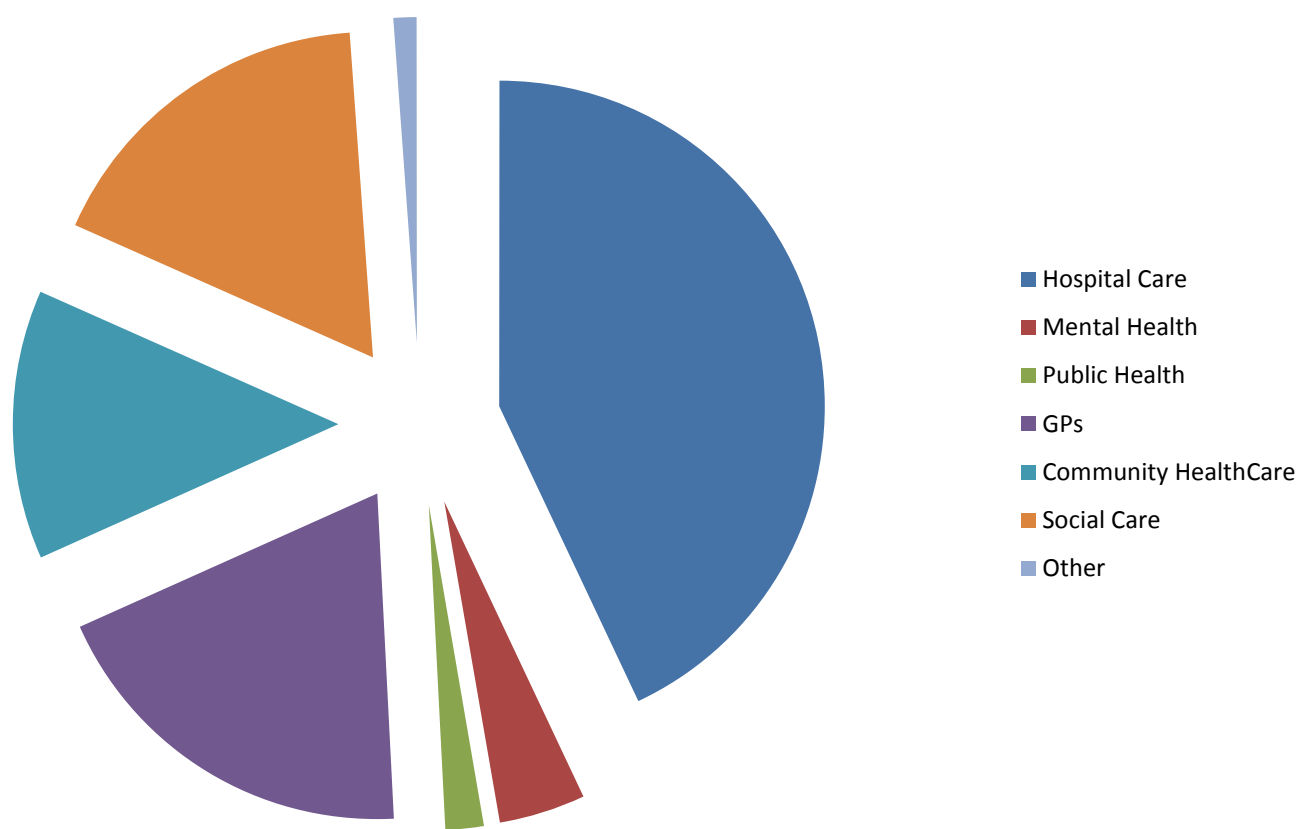


Figure 3 – Indicative spending of health and care funding in Leeds

Children and Families Trust Board

The Children and Families Trust Board brings together senior representatives from the key partner organisations across Leeds who play a part in improving outcomes for children and young people.

They have a shared commitment to the Leeds Children & Young People's Plan; the vision for Leeds to be the best city in the UK for children and young people to grow up in, and to be a Child Friendly city that invests in children and young people to help build a compassionate city with a strong economy.

In Leeds, the child and family is at the centre of everything we do. All work with children and young people starts with a simple question: what is it like to be a child or young person growing up in Leeds, and how can we make it better?

The best start in life provides important foundations for good health. Leeds understands the importance of focussing on the earliest period in a child's life, from pre-conception to age two, in order to maximise the potential of every child.

The best start in life for all children is a shared priority jointly owned by the Leeds Health and Wellbeing Board and the Children & Families Trust Board through the Leeds Best Start Plan; a broad collection of preventative work which aims to ensure a good start for every baby.

Under the Best Start work in Leeds, babies and parents benefit from early identification and targeted support for vulnerable families early in the life of the child. In the longer term, this

will promote social and emotional capacity of the baby and cognitive growth (or the development of the child's brain).

By supporting vulnerable families early in a child's life, the aim is to break the cycles of neglect, abuse and violence that can pass from one generation to another.

The plan has five high-level outcomes:

- Healthy mothers and healthy babies
- Parents experiencing stress will be identified early and supported
- Well prepared parents
- Good attachment and bonding between parent and child
- Development of early language and communication

Achieving these outcomes requires action by partners in the NHS, Leeds City Council and the third sector. A partnership group has been established to progress this important work.

Leeds Health and Wellbeing Board

The Health and Wellbeing Board helps to achieve the ambition of Leeds being a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest.

The Board membership comprises Elected Members and Directors at Leeds City Council, Chief Executives of our local NHS organisations, the clinical chairs of our Clinical Commissioning Groups, the Chief Executive of a third sector organisation, Healthwatch Leeds and a representative of the national NHS. It exists to improve the health and wellbeing of people in Leeds and to join up health and care services. The Board meets about 8 times every year, with a mixture of public meetings and private workshops.

The Board gets an understanding of the health and wellbeing needs and assets in Leeds by working on a Joint Strategic Needs Assessment (JSNA), which gathers lots of information together about people and communities in the city.

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

Healthwatch Leeds

People and patients are at the heart of our improvement in health. This means their views are at the heart of how staff and organisations work and that they are at the heart of our strategy.

Healthwatch Leeds is an organisation that's there to help us get this right by supporting people's voices and views to be heard and acted on by those who plan and deliver services in Leeds.

Chapter 7

Working with partners across West Yorkshire

Leeds will make the most difference to improving our health by working together as a city, for the benefit of people in Leeds.

There are some services that are specialist, and where the best way to reduce inequalities, improve the quality of services and ensure their financial sustainability is to work across a larger area. In this way we are able to plan jointly for a larger population and make sure that the right services are available for when people need them but without any duplication or waste.

NHS organisations and the council in Leeds are working with their colleagues from the other councils and NHS organisations from across West Yorkshire to jointly plan for those things that can best be done by collaborating across West Yorkshire.

This joint working is captured in the [West Yorkshire and Harrogate Health and Care Partnership](#).

The West Yorkshire and Harrogate Health and Care Partnership is built from six local area plans: Bradford District & Craven; Calderdale; Harrogate & Rural District; Kirklees; Leeds and Wakefield. This is based around the established relationships of the six Health and Wellbeing Boards and builds on their local health and wellbeing strategies. These six local plans are where the majority of the work happens.

We have then supplemented the plan with work done that can only take place at a West Yorkshire and Harrogate level. This keeps us focused on an important principle of our health and care partnership - that we deal with issues as locally as possible

The West Yorkshire and Harrogate Health and Care Partnership has identified nine priorities for which it will work across West Yorkshire to develop ideas and plan for change, these are:

- Prevention
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised services
- Hospitals working together
- Standardisation of commissioning policies

Chapter 8

Making the change happen

The work to make some changes has already started. However, we don't yet have all of the answers and solutions for exactly how we will deliver the large changes that will improve the health and wellbeing of people in Leeds.

This will require lots of joint working with professionals from health and care, and importantly lots of joint working with you, the public as the people who will be pivotal to the way we do things in future.

We will work with partners from across West Yorkshire to jointly change things as part of the West Yorkshire and Harrogate Health and Care Partnership (where it makes sense to work together across that larger area). Figure 4 (below) shows the priorities for both plans.



Chapter 9

How the future could look...

We haven't got all the answers yet, but we do know what we would like the experiences and outcomes of people in Leeds to look like in the future.

We have worked with patient groups and young people to tell the stories of 8 Leeds citizens, and find out how life is for them in Leeds in 2026, and what their experience is of living in the best city in the country for health and wellbeing.

***NOTE - This work is on-going. Upon completion, we will have graphic illustrations in videos produced for each of the cohorts:**

1. Healthy children
2. Children with long term conditions (LTC)
3. Healthy adults –occasional single episodes of planned and unplanned care
4. Adults at risk of developing a LTC
5. Adults with a single LTC
6. Adults with multiple LTCs
7. Frail adults - Lots of intervention
8. End of Life – Support advice and services in place to help individuals and their families through death
9. We will also be developing health and care staff stories

Chapter 10

What happens next?

The Leeds Health and Care Plan is really a place to pull together lots of pieces of work that are being done by lots of health and care organisations in Leeds.

Pulling the work together, all into one place is important to help health care professionals, citizens, politicians and other interested stakeholders understand the 'bigger picture' in terms of the work being done to improve the health of people in the city.

Change is happening already

Much of this work is already happening as public services such as the NHS and the Council are always changing and trying to improve the way things are done.

Because much of the work is on-going, there isn't a start or an end date to the Leeds plan in the way that you might expect from other types of plan. Work will continue as partners come together to try and improve the health of people in the city, focussing on some of the priority areas we looked at in **Chapter 4**.

Involving you in the plans for change

We all know that plans are better when they are developed with people and communities; our commitment is to do that so that we can embed the changes and make them a reality.

We will continue to actively engage with you around any change proposals, listening to what you say to develop our proposals further.

We are starting to develop our plans around how we will involve, engage and consult with all stakeholders, including you, and how it will work across the future planning process and the role of the Health and Wellbeing Boards.

Working with Healthwatch

Planning our involvement work will include further work with Healthwatch and our voluntary sector partners such as Leeds Involving People, Voluntary Action Leeds, Volition and many others to make sure we connect with all groups and communities.

When will changes happen?

While work to improve things in Leeds is already happening, it is important that improvements happen more quickly to improve the health of residents and the quality and efficiency of services for us all.

Joint working

Working together, partners of the Health and Wellbeing Board in Leeds will continue to engage with citizens in Leeds to help decide on the priorities for the city, and areas that we should focus on in order to improve the health of people living in Leeds.

Alongside the Health and Wellbeing Board, the heads of the various health and care organisations in the city will work much more closely through regular, joint meetings of the Partnership Executive Group (a meeting of the leaders of each organisation) to ensure that there is a place for the more detailed planning and delivery of improvements to health and care in the city.

Who will make decisions?

Ultimately, there will be lots of changes made to the way that health and care services work in Leeds. Some of these will be minor changes behind the scenes to try and improve efficiency.

Other changes will be more significant such as new buildings or big changes to the way that people access certain services.

The planning of changes will be done in a much more joined up way through greater joint working between all partners involved with health and care services in the city (including citizens). Significant decisions will be discussed and planned through the Health and Wellbeing Board. Decision making however will remain in the formal bodies that have legal responsibilities for services in each of the individual health and care organisations.

Legal duties to involve people in changes

Leeds City Council and all of the NHS organisations in Leeds have separate, but similar, obligations to consult or otherwise involve the public in our plans for change.

For example, CCGs are bound by rules set out in law, (section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012).

This is all fairly technical, but there is a helpful document that sets out the advice from NHS England about how local NHS organisations and Councils should go about engaging local people in plans for change.

The advice can be viewed here:

<https://www.england.nhs.uk/wp-content/uploads/2016/09/engag-local-people-stps.pdf>

NHS organisations in Leeds must also consult the local authority on 'substantial developments or variation in health services'. This is a clear legal duty that is set out in S244 of the NHS Act 2006.

Scrutiny

Any significant changes to services will involve detailed discussions with patients and the public, and will be considered by the Scrutiny Board (Adult Social Services, Public Health and the NHS). This is a board made up of democratically elected councillors in Leeds, whose job it is to look at the planning and delivery of health and care services in the city, and consider whether this is being done in a way that ensures the interests and rights of patients are being met, and that health and care organisations are doing things according to the rules and in the interests of the public.

Chapter 11

Getting involved

Sign up for updates about the Draft Leeds Health and Care Plan

***NOTE –Final version will include details of how to be part of the Big Conversation**

Other ways to get involved

You can get involved with the NHS and Leeds City Council in many ways locally.

1. By becoming a member of any of the local NHS trusts in Leeds:

- Main Hospitals: Leeds Teaching Hospitals Trust - <http://www.leedsth.nhs.uk/members/becoming-a-member/>
- Mental Health: Leeds & York Partnership Foundation Trust - <http://www.leedsandYorkpft.nhs.uk/membership/foundationtrust/Becomeamember>
- Leeds Community Healthcare Trust – <http://www.leedscommunityhealthcare.nhs.uk/working-together/active-and-involved/>

2. Working with the Commissioning groups in Leeds by joining our Patient Leader

programme: <https://www.leedswestccg.nhs.uk/content/uploads/2015/11/Patient-leader-leaflet-MAIN.pdf>

3. Primary Care –Each GP practice in Leeds is required to have a Patient Participation Group

Contact your GP to find out details of yours. You can also attend your local Primary Care Commissioning Committee, a public meeting where decisions are made about the way that local NHS leaders plan services and make spending decisions about GP services in your area.

4. Becoming a member of Healthwatch Leeds or Youthwatch Leeds:

- <http://www.healthwatchleeds.co.uk/content/help-us-out>
- <http://www.healthwatchleeds.co.uk/youthwatch>

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Report of: Nigel Gray, Chief Officer System Integration, Leeds CCGs Partnership

Report to: Leeds Health and Wellbeing Board

Date: 28th September 2017

Subject: System Integration – a Blueprint for Leeds

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ 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

The Leeds Health and Wellbeing Strategy 2016-2021 sets out a clear vision that **‘Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest’**. It highlights an ambition to make sure that care is personalised and more care is provided in people’s own homes whilst making best use of collective resources to ensure sustainability. Work has progressed at pace to develop our Leeds Health and Care Plan.

Additionally the Leeds health and care system has committed to partnership values; to put people first; work as Team Leeds; and to deliver - moving to action over words.

People have told us that the lack of joined-up care is the biggest frustration for our patients, service users and carers. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together.

A key part of delivering this change is for the system to work together to develop and implement a new model of integrated care where providers are jointly accountable for population outcomes. An example of this in Leeds could be the ‘primary care home’ neighbourhood model of health and care delivery in Leeds as **local care partnerships**.

Commissioners now need to create the conditions for integrated accountable care to happen at pace and scale by moving to commissioning providers to deliver population level outcomes.

Commissioning for outcomes will mean that providers can work together in integrated, innovative ways to most effectively deliver the outcomes. The opportunity for this to happen without a move to commissioning for outcomes is limited due to current contractual restraints, inconsistent payment methods, individual organisational priorities and system pressures.

Accountable care means that providers and services will need to work together to achieve improved outcomes for people focussing on what's best for them.

This overall approach for both commissioning and providing accountable care is called **Population Health Management (PHM)**. PHM has the core principles of not differentiating between all age groups and has the whole person at its heart.

There are several key benefits to adopting a PHM approach for Leeds as, in addition to the triple aim, it will enable previously complex issues to be addressed more effectively because the system will not be as fragmented. For example:

- Parity of esteem between mental and physical health
- Better partnerships between adult and children's services e.g. work with vulnerable families to support the best start in life.
- A greater focus on the wider determinants of health to deliver outcomes.

The hypothesis is that by adopting this approach will not only lead to improving outcomes and patient experience, but it will also lead to a more sustainable health and care system. It will also, in the long term, improve system flow as the current fragmented system is one of the key reasons that patients can experience delays and issues whilst moving between services. In the future providers will be jointly responsible for improved flow across the health and care system.

Evidence to support this hypothesis is still emerging in the UK although nationally it is seen as the key solution to the 'triple aim' described in the NHS Five Year Forward View¹. Many UK health and care systems are further ahead than Leeds on their accountable care journey however none have yet fully implemented. In support of the hypothesis there is a range of transferrable evidence from well-known examples internationally.

In Leeds we have the flexibility to do this in the way that is right for local people and services. So we have developed a blueprint with stakeholders and consultants from BDO² describing how the system will move towards accountable care through a PHM approach. A draft has been shared with key stakeholders and comments have been incorporated into a final version.

As well as proposing a plan for Leeds it also sets out challenges to the system if we are to be successful. A key challenge is how we work with current regulatory frameworks which could be a barrier to change and this is now articulated in the final Blueprint (Appendix 1).

In order to implement this new way of working at pace, a process has been developed to select an 'accelerator' grouping or groups of the population. This will allow testing of the approach before moving on to other, and eventually all, population groups.

A process has taken place to assess population groups against a set of criteria appropriate for the Leeds health and care system. A key criteria was the impact of the triple aim on the

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

² BDO – Public Sector Consultants (secured through an existing CCG contract)

segments and analysis was undertaken to provide this evidence. In addition, scale of ambition, strategic alignment and prevention opportunities were also considered.

A group of commissioning and provider stakeholders considered this criteria in August 2017 and have agreed that **frailty (including end of life)** should be recommended as the first population segment.

Implications for the health and care system include: identify relevant service components to be pooled (following a period of scoping); outcomes framework to be developed for frail and end of life people in the city and new contract models agreed. Works for providers would include: formalising alliances and designing innovative delivery models to deliver the outcomes. A detailed system-wide programme of work will be developed to manage delivery of a range of workstreams.

Key next steps include developing a public facing narrative to describe these changes based on how people will experience health and care services in the future. We will also be developing an engagement plan will begin taking to citizens during the autumn, starting with each Community Committee in November/December 2017.

Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the Blueprint for Population Health Management
- Provide challenge and feedback on appropriate engagement as we move through the process
- Champion Population Health Management principles as a key delivery vehicle for the system to deliver the Leeds Health and Wellbeing Strategy

1 Purpose of this report

- 1.1 This paper provides an update on progress to develop accountable health and care working in the city through a Population Health Management approach.

2 Background information

- 2.1 People have told us that the lack of joined-up care is the biggest frustration for our patients, service users and carers. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together.
- 2.2 The Leeds and Wellbeing Board has heard about the proposal for the 'primary care home' neighbourhood model of integrated health and care delivery.
- 2.3 Progress is being made by providers to develop this model however in order to further facilitate the approach, action now needs to be taken by commissioners to create the conditions for this to happen at pace and scale.
- 2.4 The proposed approach is to change the way we commission from focussing on organisations, services and pathways to population level outcomes. This is in line with national and regional policy and is a supported direction of travel by commissioners and providers.
- 2.5 Moving towards such an approach will allow providers to work together to deliver accountable care and be jointly accountable for delivery of the outcomes. It will also facilitate integrated and joined up services for people that support all of their health and wellbeing needs and enable the 'primary care home' or neighbourhood model to be implemented across the city - as providers design service delivery to best meet the outcomes set by commissioners.
- 2.6 This overall approach for both commissioning and provision is called Population Health Management (PHM).
- 2.7 This hypothesis widely recognised nationally and internationally is that by adopting this approach we will not only improve outcomes and patient experience, but it will also lead to a sustainable health and care system. It will also, in the long term, address operational issues around system flow for which one of the key factors is our fragmented system with providers working on separate outcomes and priorities due to the way that we have traditionally contracted and commissioned services in 'siloes'. Evidence to support this hypothesis is still emerging nationally.

2.8 Delivering the Leeds Health and Wellbeing Strategy

Delivering accountable care will support the overall vision of the Leeds Health and Wellbeing Strategy and contribute to all five of its outcomes. Specifically accountable care will support the following LHWBS priorities:

Leeds HWBS Priority	How Accountable Care will support this priority
1 A child friendly city and the best start in life	Better integration between children's services and adults services meaning that vulnerable families will be better supported as a priority to give children the best start in life.
2 An age friendly city where people age well	Services that support older people will be more joined up meaning that care will be coordinated and streamlined. This will enhance people's experience of care.
3 Strong, engaged and well connected communities	Services will be designed around people's local neighbourhoods with staff working as 'one team' to meet people's health and care needs holistically. This in turn will support the development of new and existing third sector organisations that work in communities as part of the wider team.
7 Maximise benefits from information technology	Providers will need to implement new technologies and innovations in order to meet the population level outcomes. They will also need to join up systems in order to work as 'one team' and this will lead to the availability to enable enhanced health and care information.
8 A stronger focus on prevention	A key foundation of the new model of accountable care will be a focus on prevention. As well as improving wellbeing through supporting better health for longer, provider incentives will also be aligned to make sure that the accountable care system is focussed on prevention at all levels of need.
9 Support self-care with more people managing their own conditions	Self-care is a key principle of an accountable model of care. Evidence shows that health outcomes are better where people have the confidence and knowledge to manage their conditions and provider incentives will be aligned to make sure there is a focus on this.
10 Promote mental health and physical health equally	Accountable care allows focus on whole person needs rather than disease or organisation. This will facilitate and true move towards parity of esteem between mental and physical needs as well as social and wellbeing needs.
11 A valued, well trained and supported workforce	The workforce is the system's greatest asset. Currently there is a level of dissatisfaction experienced by elements of the workforce due to the fragmentation of the system and the frustration caused by being constrained in care delivery by organisational boundaries. By working in an accountable care system and in integrated neighbourhood delivery teams staff will have more autonomy over the way they work and will be able to more tangibly make a contribution towards whole person outcomes and increase staff satisfaction. Additionally teams will need to widen their skill sets and will need training and support to work in new ways.
12 The best care in the right place, at the right time	Accountable care will facilitate more effective, person centred community based services. It will support the move of appropriate services from hospital to the community and allow the establishment of integrated community based team which build on the integrated neighbourhood team model already established in Leeds. Where people need to be treated in hospital the support will be there so that they are admitted and discharged back to the community as soon as they are ready.

3. Main Issues

3.1. System Blueprint for Population Health Management

To align the broad support in the system to move towards this new approach colleagues from System Integration have worked with external public sector consultants BDO and a range of key stakeholders to develop a System Blueprint and Roadmap for achieving accountable care and Population Health Management in our health and care system.

The draft Blueprint was shared with stakeholders in July 2017 and comments received have been incorporated into this final version.

It highlights 4 key challenges for the health and care system:

1. Rapid implementation of PHM
2. System level challenges
3. Leadership and governance
4. Evolution of the Leeds Plan

There are additional challenges to the system if we are to be successful. A key challenge is how we work with current regulatory frameworks which could be a barrier to change. For example, competition, choice, Integrated Support and Assurance Process (ISAP) etc.

3.2. Commissioning Reform

There is an opportunity to strengthen current commissioning arrangements in the city to enable outcomes commissioning to facilitate integrated care. The Leeds CCGs are committed to strengthening arrangements and have implemented the 'One Voice' programme to streamline the way they work in partnership.

The Integrated Commissioning Executive (ICE) currently has a relatively narrow focus. In the light of commissioning moving towards more strategic outcomes, it has an opportunity to review its focus and breadth which could expand over time and, for example, should a focus on frailty be agreed consider more joined up older people's commissioning between health and social care partners (e.g. through the BCF). The ICE is crucial to have the oversight of investments and disinvestments made within its current remit or how this has expanded to include older people health care commissioning.

3.3. Provider Reform

There is strong clinical leadership in Leeds with effective driving of innovation and care pathway improvement.

Providers are coming together in terms of new working relationships and it is noted that formal alliance working has formed focussing initially on GP streaming in A&E. It was recognised Leeds has taken the first bold steps to become more strategic and outcome focused and integrated with the local authority.

The neighbourhood model has broad support as the key delivery vehicle as does development of local care partnerships. This aligns with the national requirements of primary care whereby 'primary care networks' have to be developed, with partnership agreements in place for 50% of localities by March 2018 and 100% by March 2019. In Leeds we have done much of the ground work to enable this to happen.

A Provider Network was established in 2016 and is recognised as a firm foundation to support provider collaboration and to manage and sign off plans for integrated working. It was noted to have a longer term aim to move to an Accountable/Local Care System or partnership to develop associated agreements such as MOUs and risk/gain sharing understanding. Since the Blueprint was drafted it has been agreed that the provider network will become the Accountable Care Development Board (ACDB).

3.4. Population Groupings

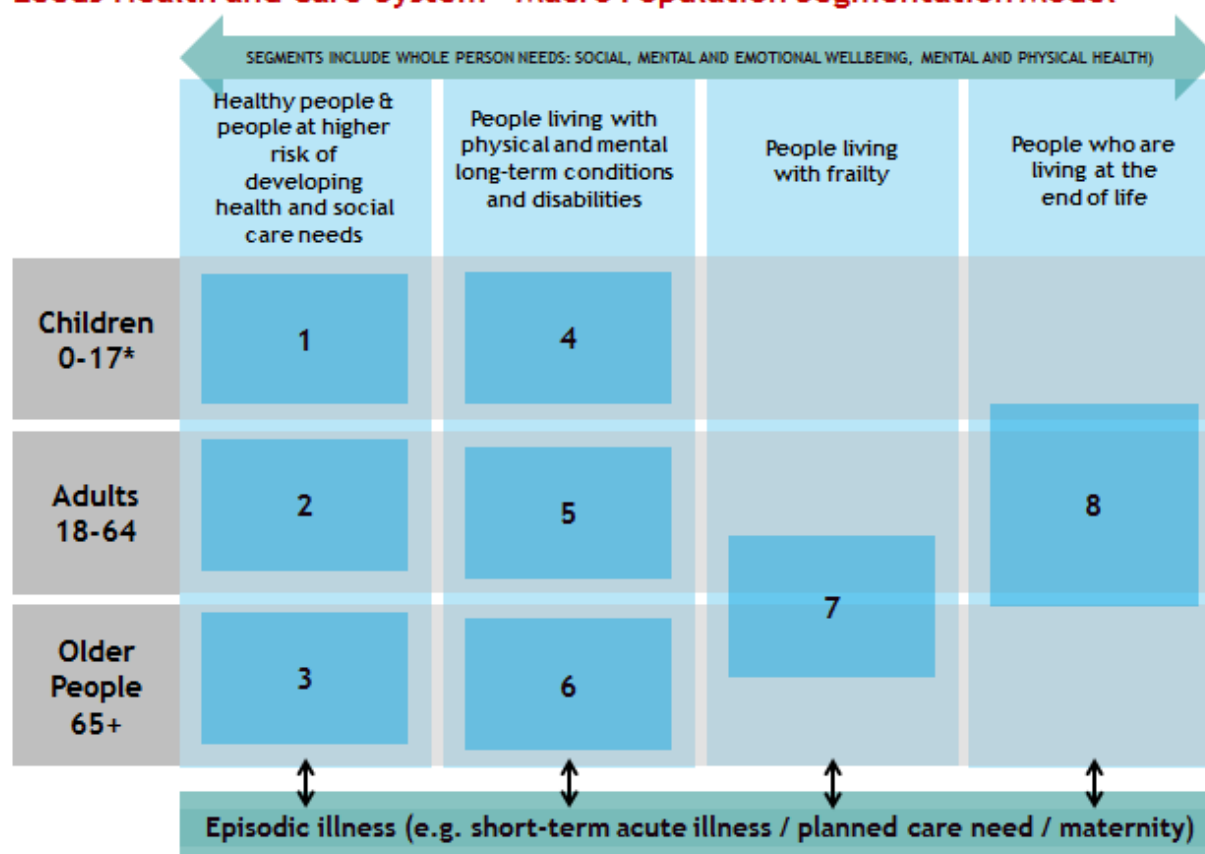
In order to support the change to commissioning for outcomes in a manageable way it is necessary to divide up or 'segment' the population into reasonable sizes that are large enough to facilitate change but small enough to test the approach and manage risk.

Selecting a population segment will mean that service components will be pooled and outcomes will be developed for that segment and provide an opportunity for commissioners to contract with a group of providers in a way that they will be jointly accountable for delivery. Current financial flows will be matched to the segment and pooled budgets could be considered.

The segmentation model outlined in the blueprint for Population Health Management proposes eight high level population segments. A key principle is that whole person needs are able to be addressed for example physical, mental health and wellbeing and social needs. People of all ages, with all types of health and care needs are included in one segment only.

The ultimate aim is for the system to move to commissioning for population outcomes and integrated provision for all the segments in due course. Selecting a segment allows the approach implemented and tested in a manageable way.

Leeds Health and Care System - Macro Population Segmentation Model



A set of criteria has also been developed by which to assess the segments and identify an 'accelerator' segment with which to test the approach before moving onto the second segment – and ultimately the whole population.

3.5. Process to recommend an accelerator segment

A process has been undertaken with stakeholders from commissioner and provider organisations to consider the segments alongside the criteria and evidence. Following this process it is recommended that **frailty including end of life** is selected as the first segment that is used to test this new way of working at scale in the Leeds Health and Care system.

Stakeholders who were part of the process considered data for each segment relating to the triple aim – health outcomes, cost and quality levels of ambition, strategic alignment and prevention opportunities and had were invited to vote for a segments after the discussions for each of the criteria.

One of the factors that was important during the process was discussions around scope and feasibility which took place towards the end of the process. Although the evidence / data pointed to people with long term conditions, or 'healthy' adults as the segments with the most opportunities ultimately the practicalities of selecting either a segment which was very large or a segment which would need to have a very wide scope felt quite overwhelming. Frailty / end of life was identified as the segment(s) where there was a good opportunity to do something different and make an impact across the system but was small enough in terms of population numbers to manage some of the associated risk.

3.6. Implications for the Health and Care System

3.6.1 Programme Plan

By committing to implementing a PHM approach for frailty / end of life the system is signing up to a reasonably large scale and long term programme of change. This programme will be led by the System Integration function and will include providers and commissioners of health and care initially, however as PHM is implemented the scope could be expanded to include other organisations such as housing, education, employment etc as the wider determinants of health.

In the first instance it is intended to develop a programme plan with workstreams, however existing groups will be used as far as possible. A high level programme plan or roadmap is included in the blueprint.

Workstreams will need to include (not an exhaustive list):

- Financial modelling and incentives alignment
- Communications and engagement
- Organisational development
- Outcomes framework development
- Contractual options appraisal
- ISAP (Integrated Support and Assurance Process – national Gateway process)
- Regulation appraisal
- Alliance agreements
- Delivery model agreement and development

3.6.2 Roadmap and timescales

Delivering PHM is a long term piece of work and more work is needed to plan a detailed timeline. The below table shows the initial timeline for the implementation of the accelerator segment, moving on to the second segment.

Key activity	Timescales
Sign off blueprint including system level changes and macro segments	Sept 2017
First accelerator segment selected	Sept 2017
Agree methodology to identify financial envelopes for all segments and produce 'first cut' of budget for initial accelerator segment	Dec 2017
Overarching outcomes framework developed	Mar 2018
Budgets confirmed for all segments	April 2018
Governance and contractual mechanism for outcome based commissioning of segment agreed. Regulatory support acquired.	Jun 2018
Shadow running of first segment & agree second segment	Jun 2018 – Mar 2019
Implementation of 'real' outcomes based contract with payments	Apr 2019 (TBC)
Next segment implemented	Apr 2019 (TBC)

3.6.3 List of boards and forums where accountable care, PHM and the Blueprint have been discussed to date

Meeting	JUNE	JULY	AUGUST	SEPTEMBER
Healthwatch Leeds Strategic Board Meeting	29-June			
Leeds West CCG Primary Care Network		20-Jul		07-Sept
Leeds South and East CCG Lead GP Group Board			01-Aug	06-Sept
Leeds North CCG Council of Members		04-Jul		12-Sept
CCG SMT		26-Jul	02-Aug 09-Aug 23-Aug	
Population Health Management (PHM)		18-Jul	15-Aug	
System Integration Board		21-Jul	25-Aug	
Leeds CCGs Partnership – Strategic Commissioning and System Integration Board		26-Jul		
Finance and Commissioning Committee		20-Jul		
Health and Wellbeing Board Workshop		20-Jul		
Provider Network (Accountable Care Development Board)		21-Jul	25-Aug	15-Sept
LTHT Board		27-Jul		
Integrated Commissioning Executive (ICE)		25-Jul	22-Aug	
Leeds Health and Care Partnership Executive (PEG)		06-Jul		08-Sept
Leeds Plan Delivery Group		26-Jul	31-Aug	
Leeds CCGs Patient Assurance Group		17-Jul		
St Gemma's Staff Conference		19-Jul		
Leeds Health and Care Board to Board Summit				12-Sept

4. Health and Wellbeing Board governance

4.1. Consultation, engagement and hearing citizen voice

- 4.1.1. A range of feedback from citizens spanning a number of years was taken into account when developing this approach. People have consistently fed back through engagements and complaints that despite the commitment and dedication of front line teams the system is fragmented, that it is complex to navigate, that there is duplication of process which can cause anxiety, stress, a poor experience and even harm.
- 4.1.2. A key task for autumn and winter 2017-18 is to develop the engagement approach to accompany this programme. Feedback has said that the blueprint in its current form is not a public facing document and therefore a public facing narrative will be developed and will align fully with the Leeds Plan narrative.

- 4.1.3. The public facing version will focus on the neighbourhood delivery model and will be around where the public and service users interface with health and care as that is where they will experience change and improvement.
- 4.1.4. A key opportunity for public engagement to take place will be the forthcoming community committees planned for the autumn where this will be discussed as a key element of the Leeds Plan.

4.2. Equality and diversity / cohesion and integration

- 4.2.1 This approach means that the needs of diverse groups can be better met in individual communities and also allows outcomes to be set for the population that take account of specific needs of people with protected characteristics or other minority or groups where identified.
- 4.2.2 With regard to integration this is a key principle of this approach and full implementation will lead to whole service integration.

4.3. Resources and value for money

- 4.3.1 This programme seeks to address the triple aim described in the Leeds Plan and therefore greater sustainability, use of resources and value for money is a key outcome of full implementation.

4.4. Legal Implications, access to information and call In

- 4.4.1 There are a number of legal implications to be worked through, not least procurement, regulation and contracting. These issues are key and will be picked up within the programme plan currently under development.
- 4.4.2 There are no access to information and call-in implications arising from this report

4.5. Risk management

- 4.5.1 The System Integration Programme Team at the CCG are managing risk via a risk register.

5. Conclusions

- 5.1 The further development of integration through commissioning for outcomes and accountable care has been discussed in Leeds for some time. Additionally there is strong support for development of the neighbourhood model and services that wrap around local communities.
- 5.2 The development of a blueprint and plan for delivering accountable care through a Population Health Management approach gives our health and care system an opportunity to progress this ambition by testing the approach on the frailty and end of life population segments, moving on to implement the approach for all segments in the population in a managed way.

6. Recommendations

The Health and Wellbeing Board is asked to:

- Endorse the Blueprint for Population Health Management
- Provide challenge and feedback on appropriate engagement as we move through the process
- Champion Population Health Management principles as a key delivery vehicle for the system to deliver the Leeds Health and Wellbeing Strategy

7. Background documents

None.

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How does this help reduce health inequalities in Leeds?

This approach allows outcomes to be set for the population that providers across the health and care system would be jointly accountable for delivering. One of the key principles of developing the outcomes framework for the population will be reducing health inequalities.

How does this help create a high quality health and care system?

Based on feedback from services users over many years a fully integrated system and care based around neighbourhood will offer an improved patient experience.

How does this help to have a financially sustainable health and care system?

Through reducing duplication, variation and by embedding prevention at all levels of health and care a sustainable system should be able to be achieved.

Future challenges or opportunities

This is a long term transformation that requires commitment by the whole system. Full implementation will take 5-10 years. There will be many challenges and opportunities along the way and it is critical that learning is captured on the journey so that full implementation can be achieved and the benefits realised.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)

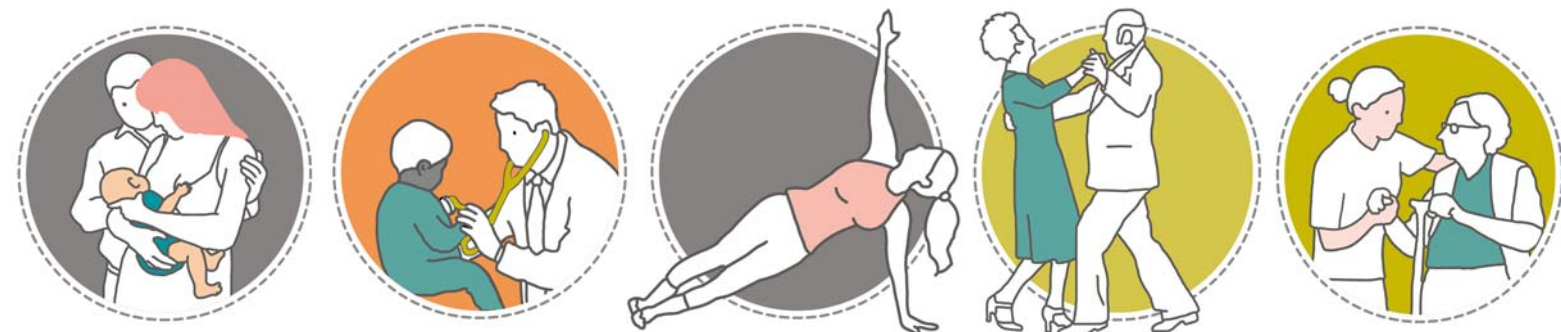
A Child Friendly City and the best start in life	✓
An Age Friendly City where people age well	✓
Strong, engaged and well-connected communities	✓
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	✓
A stronger focus on prevention	✓
Support self-care, with more people managing their own conditions	✓
Promote mental and physical health equally	✓
A valued, well trained and supported workforce	✓
The best care, in the right place, at the right time	✓



Leeds

The best city for health & wellbeing

System Blueprint for Population Health Management



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Executive Summary

Purpose

The purpose of this System document for Population Health Management (Blueprint) is to further develop and describe our vision, enhance our plans for commissioning for outcomes and integrated provision to achieve better health and care outcomes for people in Leeds.

The definition for Population Health Management (PHM) adopted by Leeds recognises that **health and wellbeing is more than just being ‘without disease’**. It moves away from managing disease in silos to an approach based on defined populations of people, who may have multiple ‘disease conditions’ or life challenges. It provides a framework for the whole population across all age groups. In Leeds, PHM is described as:

- **Improving population outcomes** through a whole system approach where commissioners and providers work together to define, measure and improve population outcomes.
- Designing, organising and integrating the full cycle of care around the needs of a population group by moving away from organisational silos towards **jointly accountable care**.
- Supported by a **strategic approach to commissioning** which measures and values delivery of key outcomes for defined population segments, rather than the traditional emphasis on processes, pathways and activities.
- Fully utilising **data and informatics** solutions to direct care interventions to where they are most needed, and better support professionals in joint working.

People have told us that the lack of joined-up care is the biggest frustration for our patients, service users and carers. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together. Reflecting the National Voices *Narrative for Person Centred Co-ordinated Care* (2013), implementing PHM will mean

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

Achieving integrated care would be the biggest contribution health and care services could make to improving quality and safety, making significant progress in reducing inequalities and making sure we have a sustainable, resilient health and care system for the future.

There has been significant progress towards this over recent months and the pace has started to build. Additionally we have wide consensus about our extended primary care neighbourhood model of health and care delivery we are aiming to achieve and we need to build on with examples of local care partnerships already starting to be established.

Towards this aim this Blueprint will:

- Build upon the starting point in Leeds, including commitment at a leadership level to a move towards PHM, a health and wellbeing focus for the residents of Leeds.

- Describe how the Leeds health and care system (as part of the wider West Yorkshire and Harrogate Sustainability and Transformation Plan) can move rapidly towards strategic outcome based commissioning and integrated provision.
- Identify the assets, strengths, opportunities and gaps that exist across Leeds to support a move towards PHM.
- Support conversations between and within organisations to develop the Leeds Health and Care Plan (Leeds Plan) and its implications for the system and for individual organisations.
- Provide a high-level Roadmap for the next steps in order to take this work forward at scale and pace.

This Blueprint has been co-produced through a process of engagement with commissioners, providers and partners. This has included undertaking over thirty individual interviews with key leaders focussing upon the vision of the future, approach to PHM and red lines/challenges at an organisational and individual level. These findings have been discussed at a number of forums (CCG Senior Management Team, Integrated Commissioning Executive, Provider Network and Partnership Executive Group, amongst others) over the course of the development of the draft Blueprint. Public engagement will form a key element of the design and implementation of new approaches to service delivery enabled through greater provider integration (see Chapter 3). For ease, a glossary of terms can be found at the end of this document - Chapter 9.

Introduction

The Leeds Health and Wellbeing Strategy 2016-2021 sets out a clear vision that **‘Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest’**. It highlights an ambition to make sure that care is personalised and more care is provided in people’s own homes whilst making best use of collective resources to ensure sustainability.

To achieve this ambition and to build on Leeds’s strengths with regard to partnership working and place-based care, we need to move to an approach that focusses on population level outcomes, leading to more sustainable health and care. We need to work as a system, to drive commissioning for outcomes and integrated provision so that providers are accountable for delivering outcomes rather than inputs and processes. We need to maximise the learning from across Leeds where new models of care have been tested at neighbourhood or locality level. We need to support providers coming together in some instances, for the first time, to establish joint accountability arrangements to respond to gaps in care.

We also need to support the creation of a new culture for health and care in our city, working ‘with’ people. We want to and engage local people in better conversations so that people are in charge of their own health and care and part of co-producing new localised, neighbourhood based integrated care models, a key strength in our city.

The scale of change required to deliver against Leeds’s challenges cannot be delivered within the current system of misaligned incentives, organisational boundaries and existing contractual processes. Transformation and improvement within organisations and pathways is of course required, but **Leeds will need to do more, across the system, in**

order to make a change at scale and pace, and respond to the increasing demand as people live longer with multiple conditions.

The Challenge and Proposed Solutions

To achieve the vision of the Leeds Health and Wellbeing Strategy and the (three) gaps in health and wellbeing; care and quality and funding and efficiency identified within the Leeds Health and Care Plan, there is a need for Leeds to **simultaneously balance** the need to:

- 1) Continue to deliver **pathway level** re-design to respond to specific system challenges as articulated in the Leeds Plan. Work also needs to continue to improve patient flow, make the city more resilient and better able to cope with fluctuations in demand.
- 2) Actively establish a PHM approach by commissioning for outcomes for a defined population segment and establishing accountable care arrangements between providers to deliver these outcomes. This is being supported through a greater emphasis on integrated commissioning between health and social care and through the establishment of an Accountable Care Development Board across Leeds.

This document identifies **four key challenges facing the system in Leeds**.

- Challenge 1: Rapid Implementation of PHM
- Challenge 2: System Level Changes
- Challenge 3: Leadership and Governance
- Challenge 4: Evolution of the Leeds Plan

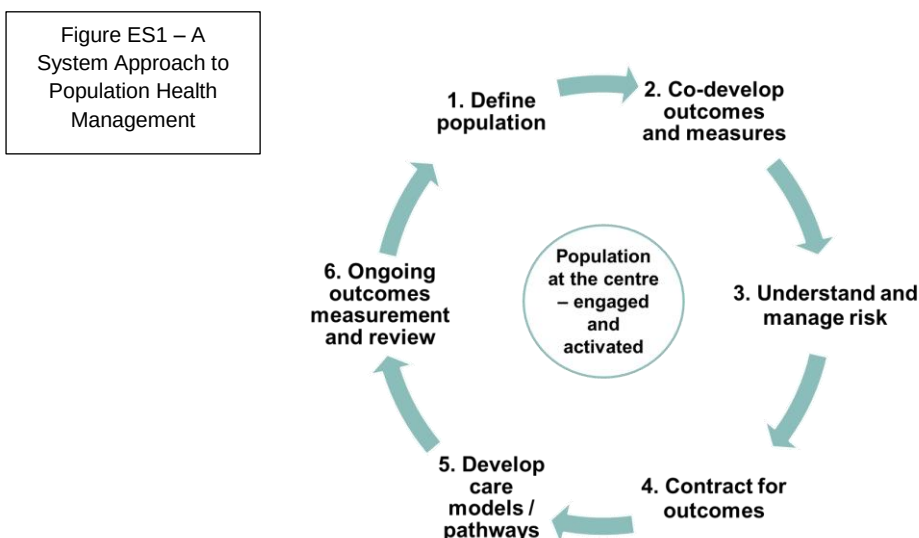
Work has been undertaken with teams across Leeds to scope and propose solutions to each of these four challenges. These are described in detail in the Blueprint and are summarised in the section below:

Challenge 1: Rapid Implementation of PHM

- The system will not deliver significant change without system change (through innovation and integration of services).
- PHM has been signed up to by the system as the route to achieve this and needs to be closely aligned to the Leeds Plan.
- Rapid progress is needed, identifying and developing the first accelerator segment and implementing commissioning for outcomes.
- Once this happens, the system can start to change. Providers have articulated their readiness for this to take place.

In order to make this rapid progress, an approach and plan has been described. This will be supported by workstreams focussing upon population segmentation, outcome based commissioning and in addition making progress with enablers such as linked data, workforce, finance, contracting and regulation. There is appetite from providers to make progress, as well as support from the Leeds Health and Care Partnership Executive Group (PEG) and leaders in the city. Within this document, a Roadmap (a high-level programme plan) is provided to enable PHM to be taken forward at scale and pace.

The cycle below sets out in high-level terms the system approach to PHM for Leeds and therefore summarises the actions that need rapidly take place with commissioners and providers in order to implement PHM. Citizens, patients, service users and carers will be engaged through the co-production of outcomes, development of care models and measurement of outcomes.



We want to **raise the level of ambition for the system**, by going beyond a focus on specific pathways or local cohorts to making improvements for whole population groups across the city.

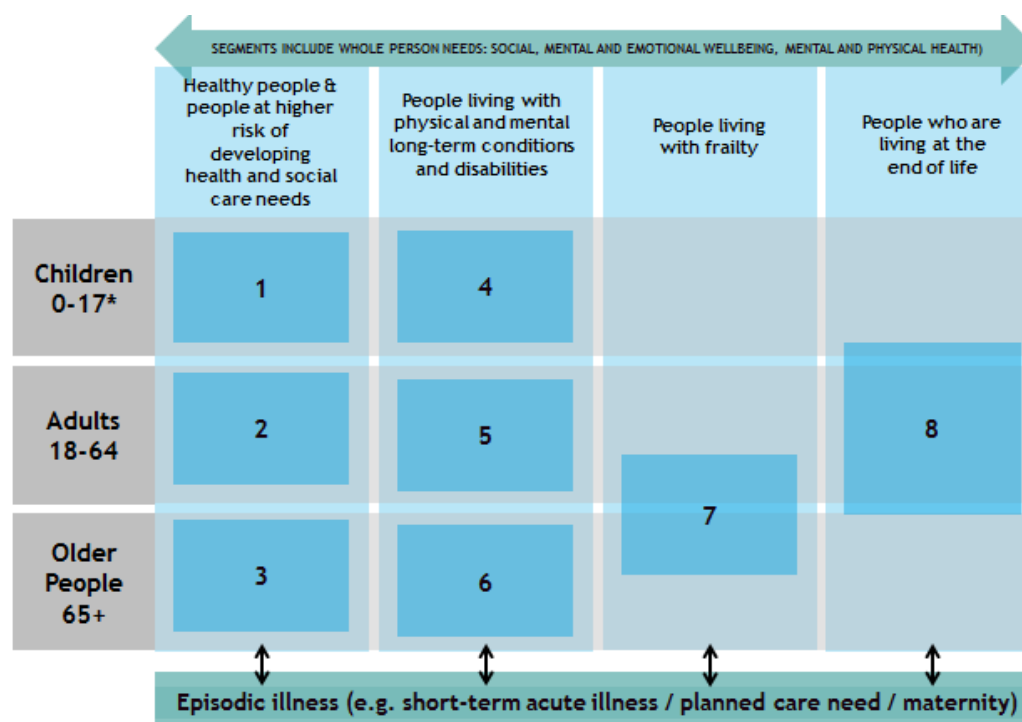
However, as this is a new and complex approach, this Blueprint recommends a pragmatic approach of starting with one population grouping or ‘segment’ and developing learning (e.g. around analysis, setting of outcomes and development of new payment systems and contracts) at pace before moving onto the other segments. The ambition is therefore to begin with one of the ‘macro’ or large scale segments (e.g. frail segment) and use this as the first population group to set outcomes for and ask providers to work in partnership to deliver integrated services for.

Leeds is also keen to maintain progress at a delivery level - there is a lot of good work underway to integrate care and improve pathways for people with multiple needs, e.g. the new model of care pilots and development of local care partnerships.

Once an initial population segment, associated outcomes and agreed budget has been defined and selected by the system, it will be vital for providers to develop and target interventions that enable delivery of the agreed outcomes. For example, in order to improve outcomes for people living with frail (one of the macro population segment as per Figure ES2 below), providers will need to understand the varying needs in different localities to determine where and how best to target care appropriately.

A proposed framework for population segmentation (Figure ES2) - with everyone in the Leeds population fitting into one of eight large scale groupings or segments, is shown below.

Figure ES2 – Proposed Macro-Segmentation Approach



- The model focuses on ‘the whole person’ at all times, and recognises that people’s broad needs and priorities for their health and wellbeing will change according to their general life stage or health status.
- All population segments contain a range of need and will include people who are generally healthy and independent, meaning the ‘Healthy people & people at risk of developing health and social care needs’ segment represents ‘all other’. It is envisaged that local delivery models will differ according to local need.
- It has been assumed that public health, adult social care and health budgets are all in scope.
- **This is a proposed model and will undergo further engagement** with key stakeholders as part of a wider Communications and Engagement plan as set out in the Roadmap.

There are currently various suggestions in Leeds for which segment should be chosen as the initial accelerator segment. The Blueprint sets out a methodology and key criteria to support this decision, summarised in the table below.

Segment selection criteria and example methodology	
Step 1: Assess against 3 'gaps' described in Leeds vision to develop shortlist <i>(N.B. Services or conditions will need to be translated into a macro population segment)</i>	
#1 Health Outcomes / Inequalities	Assess poorest performing indicators and highest contribution to health inequalities
#2 Cost to System (Leeds £)	Identify highest cost to the system (current spend, future spend, opportunities for spend reduction)
#3 Quality Gap	Where available, identify areas across the system that are known to be poor quality or unsafe e.g. lack of resource or clinical effectiveness, workforce, patient experience
Step 2: Take shortlisted population segments from step 1 and assess their alignment with strategic plans, system impact and long-term population health	
#4 Strategic Alignment	Alignment with STP, HWBS and Leeds Plan; Fit with ambition for PHM and commissioning for outcomes; Political acceptability
#5 Scale of Ambition	Extent that selected segment will create the desired impact to achieve sufficient system outcomes to meet the scale of the challenge (financial and clinical) Ability to incentivise or encourage accountable care or improve coordination of care across providers (i.e. at appropriate scale)
#6 Long-term impact on population health	Opportunity to significantly move care upstream, prevent onset or exacerbation of clinical conditions, reduce demand and/or sustain health and wellbeing in the future
Step 3: System discussion (Provider-informed) about how best to impact chosen segment e.g. new care models etc.	

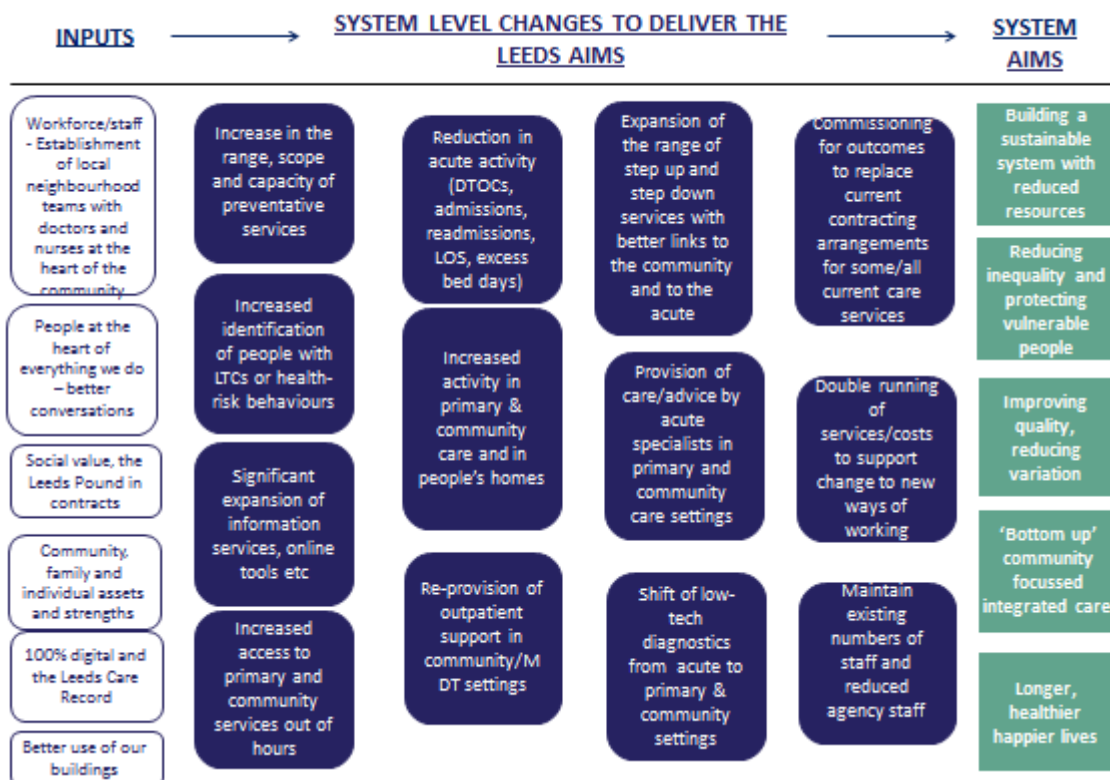
Challenge 2: System Level Changes

- There is a shared vision and each organisation has its own priorities - but there is a gap between the two.
- A framework is required to join and translate the work being undertaken into the context of the overarching vision and articulate the System Level Changes that are required to deliver our ambition. A potential draft Framework has been proposed (Figure ES3) and further work is required to further develop and sign-off these System Changes.
- This will “bunch the thousand flowers that are blooming” and test whether these initiatives are delivering what is required and intended in the strategy and vision.
- This will build on provider appetite and pro-activity, clarify the role and direction of the commissioner and set the plan for going forward in the same direction - working as an aligned system.

System Level Changes have been proposed which provide this bridge between the vision and the initiatives that are being developed, providing sight of the real impact that delivering the vision for Leeds will have. These are summarised in Figure ES3 below, setting out:

- The high level system aims encompassing the three gaps or ‘triple aim’ as well as the HWB strategy outcome relating to health and care;
- The system level changes that will contribute to the delivery of the aims:

Figure ES3 System Level Change Framework



It will be important to test how work underway already will deliver these System Level Changes and therefore how they are contributing to the delivery of one or more of Leeds' system aims.

These System Level changes can be used as a framework in order to:

- Support commissioners and providers to develop their work in line with a set of strategic and system level aims and objectives.
- Identify any gaps in scale and impact which mean that the work currently planned and underway will be insufficient to deliver against the system aims
- Support development of work at a population segment and a pathway level to address these gaps.

Further work is required in order to develop and sign-off the System Level Change Framework.

Challenge 3: Leadership and Governance

- The System Alignment process highlighted an opportunity to strengthen and develop strategic, **system level** leadership to drive PHM forward.
- The Strategic Commissioner, System Integration Function and Providers are currently working to strengthen leadership arrangements and drive this work forward, supported by an effective commissioning structure.

Evidence for this conclusion is set out within Chapter 5 of this Blueprint, together with a proposed approach for how Leadership across the system can be strengthened to deliver real, system-level change.

Challenge 4: Evolution of the Leeds Plan

- Through the System Alignment process, leaders from across the system articulated that neither the vision nor the three gaps/‘triple aim’ in the Leeds Plan are deliverable without system transformation.
- The current workstreams within the Leeds Plan are changing to understand how they deliver against the three gaps and deliver a more integrated system and PHM.
- There is a risk that work becomes pathway based and only incremental improvement is achieved so evolving the Leeds plan should be prioritised.
- It has been recognised that the Leeds Plan workstreams need to be reviewed so that it demonstrates that services need to be transformed at a system level such that greater change can result.

The Leeds Plan is being evolved to drive work at a greater scale, across the system, building upon the good work that is currently happening and utilising a PHM approach to make more significant change - commissioning for outcomes and creating accountable provision. There must be a complementary approach to the progress of the initial accelerator population segment and the continuing workstreams of the Leeds Plan.

The Blueprint sets out how the health and care system can effectively establish a population based approach to commissioning and provision of outcomes for an initial, accelerator population segment whilst simultaneously continuing to deliver priority pathways as part of on-going Leeds Plan work. Pathway, service redesign and procurement plans related to the delivery of outcomes for the initial population segment would be ‘matched’ into the work programme supporting delivery of outcomes for the initial population segment.

Figure ES4 shows the four workstreams of the Leeds Plan with the on-going service redesign work within each column. The lower part of the diagram introduces how the approach described above could impact on existing workstreams:

Figure ES4 – Impact of Segment upon Leeds Plan Workstreams



In summary, the Blueprint defines several broad ‘intentions’ for Strategic Commissioning to support the system ambition of PHM:

- To lead the **development of a set of outcomes** for the initial accelerator population segment, focusing on a manageable number of outcomes e.g. 5-10 per segment (the approach to this is set out in more detail in Chapter 6)
- Recognising current regulatory challenges, to commit to **longer-term contracts** at sufficient scale (e.g. 5+ years) in order to give Providers confidence and sustainability
- To establish a new approach to accountability for clinical, financial and reputational risks between providers as a collective and also across commissioners and providers.

- To put in place live contracts for the initial accelerator population segment/s by **April 2019** (see Finance and Contracting section in Chapter 6). This represents a commitment to move at pace, although this speed will be dependent on the level of collaboration between and with Providers and the maturity of integrated or accountable provision to take on these contracts.
- Recognising the current regulatory environment, the explicit assumption is that these contracts will be a collaborative system approach, **going out to market via procurement as a last resort**. To support this, the system will need to be clear of regulatory support to enable this as well as associated regulatory challenge and risk.
- To implement **shadow outcomes** and align incentives / remove barriers as soon as possible to enable new care models to take shape i.e. create the appropriate commissioning and contracting environment for Provider collaboration.
- To **stop** activities or reporting requirements where these are not aligned to a population/outcomes approach, and where this reduces the burden on Providers.
- To **upskill** the commissioning workforce (including finance, contracting and cultural change) to support the new ways of working required. An initial set of educational workshops is already underway to raise understanding and awareness
- Alongside work on the accelerator segment, to identify how existing working/business as usual (BAU) is aligned to the macro-segmentation framework and continue to support greater integration of pathways and services as per the principles of PHM.

The move to a population health management approach in an accountable care system is a fundamental change to traditional commissioning and service provision. As part of the process it is important that all risks need to be identified and understood by system players so that collaborative solutions can be developed to minimise risks at both a system and organisational level. This will include clinical, financial and reputational risks. Agreeing principles around risk share arrangements should be made at an early stage to provide assurance and commitment to developing the PHM approach.

A high-level Roadmap or programme plan has been produced to describe actions and timescales for delivery. A summary of key milestones in the Roadmap is detailed below. It is acknowledged that further work is required to define the scope of the inputs and outputs across the system. The table below summarises timeframes for the key, milestone steps of the plan:

Key activity	Timescales
Sign off Blueprint including system level changes and macro segments	Sept 2017
First accelerator segment selected	Sept 2017
Agree methodology to identify financial envelopes for all segments and produce 'first cut' of budget for initial accelerator segment	Dec 2017
Overarching outcomes framework developed	Mar 2018
Budgets confirmed for all segments	April 2018
Governance and contractual mechanism for outcome based commissioning of segment agreed. Regulatory support acquired.	Jun 2018
Shadow running of first segment & agree second segment	Jun 2018 - Mar 2019
Implementation of 'real' outcomes based contract with payments	Apr 2019 (TBC)
Next segment implemented	Apr 2019 (TBC)

These timescales will be amended and updated as work to implement this programme develops further. Currently, key steps include signing off the Blueprint by PEG and each organisation's Board, providing the go ahead for the further steps. These include the next key step which is the selection of the first or accelerator population group or segment.

Conclusion

It is clear that we must move away from working under great pressure to address the symptoms of a fragmented system and move towards investing time and effort in fixing the system - delivering integrated, accountable services focussed upon the delivery of outcomes and not measuring inputs and processes. This will be a long term transformation. Providers are already progressing new service models and there are pockets of good practice across the city. The key is to act and to lead as a whole health and care system, harnessing this impetus and commitment to free providers from current contractual structures so that they can truly innovate and integrate care around populations of need.

In conclusion, it is clear that the city is keen to make progress and providers feel there is a risk that they could be held back by commissioners at present. It is also clear that were the system to select an initial accelerator population segment with providers and that that it wished to contract for this differently in a period of time, that this would provide momentum for the work described in this document. This is seen as a key opportunity and next step and one that should be taken soon in order to build upon the good work already happening across providers demonstrate and put in to practice the role of the strategic commissioner and system integration function, test out emerging provider alliances, and to show commitment to PHM at a system level. Leeds is in a good place to do this.

The document/Blueprint sets out how this can be achieved through the following chapters:

Chapter	Content
1	Introduction
2	Progress to date
3	Challenge 1 - Rapid Progress with PHM
4	Challenge 2 - System -Level Changes
5	Challenge 3 - System Leadership and Governance to take forward PHM
6	Challenge 4- Evolving the Leeds Plan
7	Organisational Impact of moving towards PHM and delivering the Blueprint
8	Roadmap and Project Management

1 - Introduction

The Leeds Health and Wellbeing Strategy 2016-2021 sets out a clear vision that ‘Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest’. It highlights an ambition to make sure that care is personalised and more care is provided in people’s own homes whilst making best use of collective resources to ensure sustainability.

Additionally the NHS England document “Next Steps on the NHS Five Year Forward View (March 2017)” highlighted three gaps or the ‘triple aim’ for health and care:

- Health and Wellbeing
- Care and Quality
- Funding and Efficiency

These strategies highlight how we need to start working together in a more jointly accountable way in order to close these gaps. This has formed the basis of the Leeds Health and Care Plan (the Leeds Plan) as well as the regional West Yorkshire and Harrogate Sustainability and Transformation Plan (WYH STP).

As part of the ‘One Voice’ review of CCG activities a ‘System Integration’ function has been established by the Leeds CCGs to work closely with commissioners and providers to facilitate and support this key transformation in Leeds.

This Blueprint describes the current status of work to deliver upon the system priorities set out in the guidance above and provides a series of next steps to ensure this vital work can be taken forward at scale and pace.

1.1 Background

Health and care are facing unprecedented challenges. These challenges are not just about affordability, we also know that we are not achieving the best possible outcomes for people and there are still some unacceptable health inequalities that we have not tackled. In addition, we continue to face huge rises in demand, capacity and system flow pressures.

We need to change the way we work so that population level outcomes can be improved and health and care services can become sustainable and health inequalities reduced further. We need to work as a system, to drive commissioning for outcomes and integrated provision so that providers are accountable for delivering the outcomes.

Across Leeds there are a multitude of new models of care being tested at neighbourhood or locality level. These ‘test-beds’ have developed, bottom up, to respond to local population need. The models of care which have developed across Leeds demonstrate different facets of a Population Health Management (PHM) approach including capitated devolved budgets to providers, outcomes based commissioning, providers working together in integrated health and care teams to meet the needs of defined populations and asset based models of care built around activated patient groups.

Currently we are also seeing providers coming together, for the first time, to establish joint accountability arrangements to respond to gaps in care (for example: GPs in A&E, Extended Access to Primary Care and “Primary Care Home” - enhanced neighbourhood teams.)

These models of care are developing invaluable awareness, capabilities and learning across commissioning and providers in different facets of PHM. However, there are some system gaps between these models of care and as articulated in the Leeds Plan to move towards a PHM approach to the commissioning and provision of improved outcomes for people in Leeds.

A similar **concern** is demonstrated within the Leeds Health and Care Plan (The Leeds Plan). The Leeds Plan is explicitly framed as a plan that will address the three gaps or ‘triple aim’ and move the system towards a PHM approach. However, the Leeds Plan is based on four programmes designed to deliver pathway level deliverables (i.e. improving efficiency in secondary care) and does not necessarily improve working at a system level.

The scale of change required to deliver against Leeds’ challenges cannot be delivered within the current system of misaligned incentives, organisational boundaries and existing contractual processes. Transformation and improvement within organisations and pathways is of course required, but Leeds will need to do more, across the system, in order to make a change at scale and pace.

To achieve the vision of the Leeds Health and Wellbeing Strategy and the (three) gaps in health and wellbeing; care and quality and funding and efficiency identified within the Leeds Health and Care Plan, there is a need for Leeds to simultaneously balance the need to:

1. Continue to deliver pathway level re-design to respond to specific system challenges as articulated in the Leeds Plan. Work also needs to continue to improve patient flow, make the city more resilient and better able to cope with fluctuations in demand.
2. Actively establish a PHM approach by commissioning for outcomes for a defined population segment and establishing accountable care arrangements between providers to deliver these outcomes. This is being supported through a greater emphasis on integrated commissioning between health and social care and through the establishment of an Accountable Care Development Board across Leeds.

In order to achieve these simultaneous aims we will need to have effective system leadership, a changing relationship with providers and across providers, and a clear vision of both the destination and the route to get there.

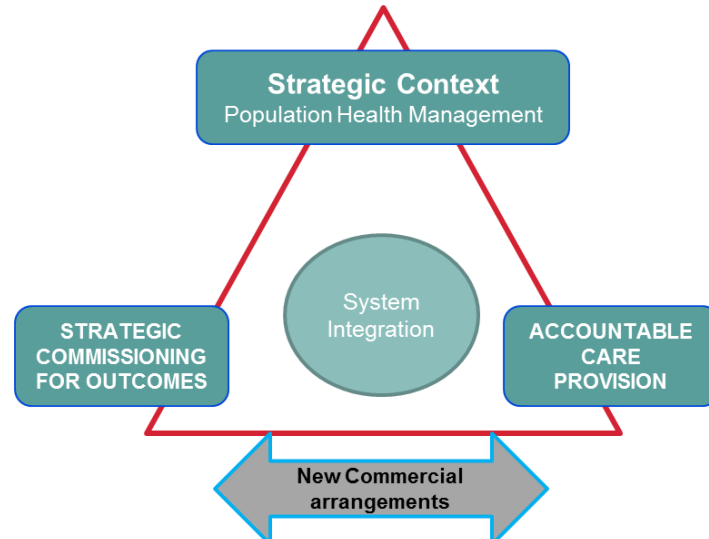
1.2 Population Health Management

The definition for **Population Health Management (PHM)** adopted by Leeds recognises that health and wellbeing is more than just being 'without disease'. It moves away from managing disease in silos to an approach based on defined populations of people, who may have multiple 'disease conditions' or life challenges. It provides a framework for the whole population across all age groups. In Leeds, PHM is described as:

- Improving population outcomes through a whole system approach where commissioners and providers work together to define, measure and improve population outcomes.
- Designing, organising and integrating the full cycle of care around the needs of a population group by moving away from organisational silos towards jointly **accountable care**.
- Supported by a **strategic approach to commissioning** which measures and values delivery of key outcomes for defined population segments, rather than the traditional emphasis on processes, pathways and activities.
- Fully utilising informatics solutions to direct care interventions to where they are most needed, and better support professionals in joint working.

Accountable care and strategic commissioning for outcomes are mutually dependent and must work in tandem to prevent either element from running too far ahead or being stalled by the rest of the system. The vision for PHM is summarised in Figure 1 below:

Figure 1 – Population Health Management Approach



A key objective of the *One Voice* programme, undertaken across the Leeds CCGs from Autumn 2016, was to support traditional commissioning functions to move towards a Population Health Management approach across Leeds. The formation of the Leeds Clinical Commissioning Groups Partnership across the Leeds CCGs will enable the establishment of a PHM approach through:

1. Establishing a **Strategic Commissioning** function, integrating previously separate commissioning teams and functions.
2. Establishing a **System Integration (SI) Function** to proactively establish a PHM approach by facilitating a move to commissioning for population level outcomes alongside the development of providers to deliver population level outcomes through accountable care arrangements. The role of the SI function is to:
 - a. Develop system relationships
 - b. Facilitate joint accountability
 - c. Facilitate provider development
 - d. Enable a shift to a population approach to commissioning and provision
 - e. Develop a risk and gain share approach across the system
 - f. Support leaders to drive system change
3. At the same time, providers across the city are working together more closely than ever before through the newly formed Accountable Care Development Board which includes representation from all providers including the Third Sector and General Practice.

This approach harnesses the world leading capabilities of the organisations across Leeds and allows innovation at a community level to maximise the value of public services across the city.

1.3 Purpose of this document:

The purpose of this document is therefore to:

- Describe and acknowledge the starting point in Leeds, including the level of commitment at a leadership level to a move towards Population Health Management (PHM)
- Describe how the Leeds health and care system (as part of the wider West Yorkshire and Harrogate Sustainability and Transformation Plan) can move rapidly towards Population Health Management, outcome based commissioning and integrated provision
- Identify the assets, opportunities and gaps that exist across Leeds to support a move towards PHM
- Support conversations between and within organisations to develop the plan and its implications for the system, and for individual organisations
- Provide a plan for the next steps in order to take this work forward at scale and pace.

2 - Progress to Date

We are a system of people and therefore the perception of our starting point can only be ascertained through understanding the views of the people within the system. A process termed “**System Alignment**” has therefore been undertaken through which the views of over thirty leaders from across the system have been gathered. This has focussed upon their individual vision for the future, their understanding and articulation of where Leeds is now, and their view for how the work can be taken forward. Areas of both consensus and divergence have been identified at an individual and organisational level. The conclusions from this work have been subsequently tested with commissioners collectively, providers collectively and then at a system level, using a discussion at the Leeds Health and Care Partnership Executive Group (PEG), Integrated Commissioning Executive and Provider Network to consider and debate the output from the process.

2.1 Findings from System Alignment

This section sets out findings from the **System Alignment** process at a high-level:

The Case for Change

Across the leaders of the system, it was agreed that change was needed with drivers for change falling into the following areas:

- **Financial sustainability** - during discussions, the sense of urgency was articulated differently, ranging from a sense that the challenge is so large as to be difficult to address to a feeling that Leeds is less challenged than other areas.
- **System sustainability** - this was seen as a key driver with the ageing population and increases in people with long-term conditions placing pressure upon the system. Added to this, the pressure of in year and resilience was articulated.
- **Poor investment choices** - leaders stated that the reason the system is failing is due to insufficient investment in prevention and primary care. Although there has been investment in keeping people out of secondary care, it was felt that this on its own will not be effective without up-stream investment at the same time. A key driver of this challenge is that there are misaligned incentives for providers, and not an effective **link between payment and the outcomes** delivered.
- **Quality of care** - leaders frequently cited quality as ‘central’ or more important than finance. There was also concern about health inequalities with Leeds becoming a ‘twin track city’. It was stated that quality of care was being negatively impacted by a lack of staff, and pressures on frontline staff.

Leaders’ Reflections on the Vision for the Future

Leaders expressed clear consensus on the vision for the future as articulated in the Leeds Health and Wellbeing Strategy. Key elements articulated included the development of a single workforce, strengths based / asset based / working ‘with’ approaches and a focus on locally tailored services. Principles for the future included:

- Continue to build on Leeds’ growing role and reputation for regionally and nationally for strong partnership working and community-focussed approaches.
- A need for a **consistent narrative** that was easy to understand and was shared across the system - ‘one version of the truth’. As a key test, this should set out how

the future will be different in simple terms and should be meaningful for, for example, front-line clinical staff.

- Focussing upon “unblocking the system” and “moving away from institutional blame”.
- Developing a culture for collective quality improvement that focusses on solving problems at a **system level**.
- A conceptual shift where providers are **accountable for populations across the whole care pathway** rather than for individual services.

Leaders' Vision for Strategic Commissioning

It was agreed amongst leaders that the strategic commissioner in the future must provide leadership in the system and create the environment for providers to deliver more integrated care. The commissioner would make increased use of its levers to change the incentives and money flows in the system to deliver the Leeds vision, and to enact this would require different skills to those currently within the commissioning organisations.

The vision for the future was described in different ways, but there were some common elements:

- The commissioner would commission at the city wide level, supporting the Leeds Health and Wellbeing Board in setting **the strategic direction and the outcomes for the city**. Outcomes based contracts would be monitored over a longer period of time, allowing a degree of local variation - devolving micro-commissioning decisions down to local teams. Some of the current commissioning functions would sit within integrated providers and others would potentially sit across a larger footprint, for example at a West Yorkshire level.
- There was a desire for **commissioning to join up** across health and the local authority - however leaders reported scepticism about how and when this will happen.
- Commissioning at a STP level - West Yorkshire and Harrogate where appropriate.

Leaders' Vision for Integrated Provision

Many leaders did not believe that a new structural solution (i.e. an Accountable Care Organisation ACO) was required or likely, but that more of an **alliance or partnership** of providers may be appropriate. It was agreed that one, lead provider could prevail but no consistent view regarding which organisation this was most likely to be at this stage.

Many leaders identified common components of the potential future model of health and care delivery: a model that is delivered in 13 neighbourhoods that brings together a range of providers - drawing heavily on the national Primary Care Home model. It was articulated that the teams from across providers would be **collectively accountable** to local population groups and would support approximately 30-50,000 people in each locality - a key strength for the city.

Above all, relationships between organisations and individuals and the building of trust were seen as vital - with the proposed collaboration to deliver GP services in A&E a positive first step in developing provider integration and test bed.

The Level of Ambition

Some leaders felt that “**everything is in scope**” including social care and children’s services for example. The management of financial risk was key to this however, and would require further work to clarify and mitigate.

There was divergence amongst leaders in relation to the **pace** of the move towards PHM: in the short-term being too ambitious could result in paralysis and a lack of progress; too small a scale could result in a lack of material impact and buy-in from providers. A staged approach was felt most appropriate, and whilst important to understand the whole system challenge there was appetite to **start in one area first** to demonstrate progress. This was discussed and a number of leaders suggested frailty as the segment to start with. However, there were concerns that there will be gaps - for example, starting with frailty can mean that healthy ageing and early intervention and prevention are overlooked.

In line with the long term level of ambition of ‘everything’ being in scope, it was suggested that, in addition, starting with a few pathways such as respiratory, diabetes and COPD in the first year could represent positive progress, with these then ‘bundled’ up and aligned into a segment, ready for an outcomes based alliance contract.

Making Change Happen

Pace

There is a desire to move at pace, but a concern that this is not happening - a common theme was the potential lack of capacity and capability in the system to drive this forward. Many leaders from across commissioning and provision highlighted the need to “**just get on with it**” as this will demonstrate early results and prove that it can be done and is not solely theoretical. Linked to the issue of capacity in the system to make change happen is the recognition that there is currently concern around the system’s ability to fund large scale transformation to equivalent levels as other areas nationally who have made greater progress.

Providers

Generally, providers were keen to start making progress and wanted to take the lead in developing solutions. Suggested tasks included working with commissioners to identify the budget for a population segment, identifying outcomes to be achieved for that population segment, allowing the providers to make **rapid progress** in the design of an integrated and innovative set of services for that segment.

System Leadership

Strong leadership across the system was acknowledged and highlighted as crucial to drive change forward. There was a perception that system wide leadership could be further developed and strengthened. Although there had been great progress in Leeds in terms of building strong partnerships. Leaders were keen to ensure that there is one voice from commissioners and that leadership arrangements are clear and well understood. They also felt there would be benefit in consolidating existing arrangements and communicating more effectively as to the role of each group and what decisions it can make.

Concerns, Challenges and Barriers

From across the leaders of the system, a number of key concerns were raised:

- A link is needed between the Leeds Health and Wellbeing Strategy, the Leeds Plan and the work that is currently underway within the Leeds Plan workstreams and within providers.
- Strengthened governance is required to oversee and assess the progress of local initiatives.
- There is a potential lack of aligned incentives across the system to support new ways of working.
- The Leeds Plan workstreams may not be **broad enough** to deliver against the system-wide challenges facing Leeds, and without transforming the system by **changing contractual structures and incentives** the workstreams will not be able to deliver.
- Concern about **lack of engagement** with both Leeds Teaching Hospital (LTH) and the elected membership.
- A request to ensure that taking a system view does not lose sight of local representation.
- Concern that moving to an ACS entails merger or acquisition.
- It was highlighted that there could be a mismatch between agreements reached in public and in meetings between organisations that sometimes behaviours did not match this approach leading to an **unravelling of agreements** reached jointly after meetings.
- The lack of evidence about the effectiveness of accountable care systems in reality (as opposed to the theory).
- Concerns that some approaches may not necessarily reduce costs - for example, Primary Care Home, shifting care setting from acute to community, etc.
- A requirement for an appreciation of the Regulatory environment within the Health and Care System and a reflection on national learning or experiences.

Summary Feedback from Engagement with Finance Leaders

A series of one-to-one meetings were also held with the finance leaders from each of the partner organisations, to both engage them with the PHM discussion from an early stage and to gain an understanding of their appetite for the key financial issues that will likely result from the implementation of PHM from a finance and contractual perspective - namely a shift in financial risk between all organisations. Summary findings included:

- All finance leads are fully conversant with PHM, its principles and the potential impact this could have financially. Finance leaders were in agreement that **something different was needed contractually** and were open for such a change to happen across the city (although it must be noted that this question was asked without a specific context - no specifics around potential contractual values were discussed for example).
- Leaders stated that the PHM approach should align to existing West Yorkshire programmes (STP, WYAAT, etc).
- It is vital that the application of high level population segmentation and its impact on the more specialist acute work that LTH currently delivers must be carefully addressed (as payment for this being aggregated within wider payments for more general care may result in inappropriate reimbursement for this specialist work).

- All organisations identified that greater partnership working has been proposed and discussed many times before, yet had demonstrated varied results - this was felt to be due to a combination of issues, including:
 - a lack of a **single, clear vision across organisations**, with an implementable plan to progress and strengthen partnership working across all organisations.
 - a lack of a burning platform - financial pressures in the system are often bailed out centrally or by the economy, meaning there is a reduced, real impetus for change.
 - a historical culture between organisations that does not support integrated working - often support for partnership is stated, yet organisations **revert to original organisational silos** when faced with immediate pressures; and the use of continued **competitive tendering** from commissioners does not embody partnership working between all Leeds partner organisations.
- Yet all partner organisations have identified that real change must happen - it was recognised that a **disassociation** between services and organisations (specific services do not have to be delivered by specific organisations) could benefit the entire care economy.

Overall, all finance leaders are sufficiently ready and willing to engage with PHM and both support and inform all future discussions around a possible implementation programme.

2.2 Summary of the Leeds Plan

The Leeds Health and Care Plan describes how we will address the ‘triple aim’ for the health and care system:

1. Health and wellbeing
2. Care and quality
3. Funding and efficiency.

There is significantly strong ownership of the Leeds Health and Care Plan aims and ambitions across the city and the plan itself forms the Leeds component of the wider West Yorkshire and Harrogate Sustainability and Transformation Plan. The overarching aims of the Leeds Plan are summarised below.

<i>A plan that will improve health and wellbeing for all ages and for all of Leeds which will...</i>		
Protect the vulnerable and reduce inequalities	Improve quality and reduce inconsistency	Build a sustainable system within the reduced resources available
<i>Our community health and care service providers, GPs, local authority, hospitals and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that...</i>		
Have citizens at the centre of all decisions and change the conversation around health and care		
Build on the strengths in ourselves, our families and our community; working with people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong		
Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens		
Use neighbourhoods as a starting point to further integrate our social care, hospital and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis		
Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do		
Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire		

Delivery of the Leeds Health and Care Plan priorities is structured through a programme of four workstreams: Prevention, Proactive Care, Optimising Secondary care and Urgent Care and Rapid Response supported by enabler programmes in informatics, workforce and estates. The SRO and Programme lead of each programme are responsible for the delivery of priority areas of pathway change. However it is understood that the Leeds Plan in its widest sense also includes all the workstreams underway in support of delivery of the Health and Wellbeing Strategy, as articulated in Figure 2.

Figure 2 – The Leeds Health and Care Plan

Draft version 2 Date 30/9/17				
Leeds Health and Care Plan				
By 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest				
A plan for all ages and for all of Leeds that will...				
Protect the vulnerable and reduce inequalities		Improve quality and reduce inconsistency		Build a sustainable system within the reduced resources available
Our hospitals, community health and care service providers, GPs, local authority and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that...				
Change the conversation around health and care and have citizens at the centre of all decisions				
Build on the strengths in ourselves, our families and our community; working with people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong				
Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens				
Use neighbourhoods as a starting point to further integrate our health, social care and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis				
Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do				
Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire				
What this means for me...	"Living a healthy life to keep myself well"	"Health and care services working with me in my community"	"Hospital care only when I need it"	"Get rapid help when needed to allow me to return to managing my own health in a planned way"
Key actions that will be undertaken	1-We will promote awareness and develop services to ensure the Best Start (conception to age 3) for every baby, with early identification and targeted support early in the life of the child. 2-We will promote the benefits of physical activity and improve the environments that encourage physical activity to become part of everyday life. 3-We will maximise every opportunity to reduce the harm from tobacco and alcohol, including enhancing the contribution by health and care staff. 4-We will have new accessible, integrated services that support people to live healthily and promote emotional health and wellbeing for all ages, with a specific focus on those at high risk of developing respiratory, cardiovascular conditions. 5-We will have a new, locally-based community service, 'Better Together', that can better build everyday resilience and skills in our most vulnerable populations.	1-People living with severe breathing difficulties will know how to manage activity issues due to their illness and have a supportive plan about what's important to them by December 2017. 2-People living with severe frailty will be supported to live independently at home where possible, instead of having to go in and out of hospital. 3-People at high risk of developing diabetes and those living with diabetes will have access to support programmes to give them the confidence and skills to manage their condition by December 2017. 4-We will take the best examples where health and care services are working together outside of hospital and make them available across Leeds, for example music and joint services.	1-Patients will stay the right time in hospital. 2-Patients with a mental health need will have their needs met in Leeds more often rather than being sent elsewhere to receive help. 3-We will meet more of patients' needs locally by ensuring their GPs can easily get advice from the right hospital specialist. 4-We will ensure that patients get the right tests for their conditions. 5-We will reduce the visits patients need to take to hospital before and after treatment. 6-We will ensure that patients get the best value medicines.	1-We will review the ways that people currently access urgent health and social care services including the range of digital points of access. The aim will be to make the system less confusing, allowing a more timely and consistent response and when necessary appropriate referral into other services. 2-We will look at where and how people's needs are assessed and how emergency care planning is delivered (including end of life), the aim to join up services, focus on the needs of people and where possible maintain their independence. 3-We will make sure that when people require urgent care, their journey through urgent care services is smooth and that services can respond to increases in demand as seen in winter. 4-We will change the way we organise services by connecting all urgent health and care services together to meet the mental, physical and social needs of people to help ensure people are using the right services at the right time.
These will be supported by...				

The current pathway based structure of the Leeds Health and Care Plan does not reflect the facets of a PHM approach insofar that it is largely pathway and service / sector based as opposed to population based.

The system alignment work described above has highlighted concerns from leaders that in its current form the Leeds Plan will not deliver the three gaps or ‘triple aim’ needed.

It is recognised that there is a need to develop and evolve the Leeds Plan to demonstrate how the plan drives and supports a PHM approach whilst also recognising the need to maintain delivery of pathway based approaches and in particular in advance of winter. It needs to describe how we manage the present in the context of the future.

2.3 Summary of New Models of Care “Test Beds”

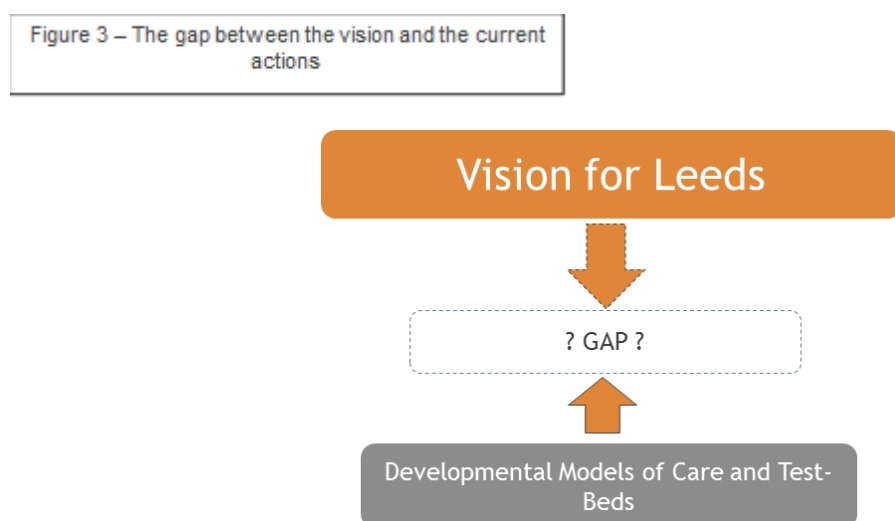
During the system alignment process a number of test beds for New Models of Care were identified which represent positive progress in a number of key areas. These areas include Live Well Leeds; Primary care based musculoskeletal services and the Neighbourhood Leadership Model and provide examples of where good practice can be achieved.

However, achieving material impact across the city through scaling up these test beds remains a challenge. In addition, it is vital that, in future, initiatives are developed and delivered consistently with the principles of system working, integrated provision and outcome based commissioning and through an agreed clinical and care delivery model for the city.

2.4 Current Progress

Discussion with leaders across the system have described a picture where there is, across Leeds, an agreed vision but a lack of a plan for how this will be progressed at a system level. Therefore, there are areas where good work is being taken forward by providers and commissioners at a small scale. This is positive, proactive and will deliver benefit. However, leaders felt that the work lacks scale, is fragmented and the link with the system vision is unclear - it has been described as “a thousand flowers blooming”.

Figure 3 below demonstrates the gap that exists between the Vision for Leeds and the work that is currently underway.



Currently the Leeds Plan workstreams also describe a focus on work that is structured around organisational and pathway boundaries (i.e. improving efficiency in secondary care). The workstreams therefore currently do not reflect the system wide solution described in the overarching aims. The risk is that without transforming the system the Leeds Plan workstreams will not deliver the ‘triple aim’ across Leeds. PHM provides a route to drive this transformational, system wide change. There is therefore an opportunity to review these workstreams in the light of system integration.

Therefore the challenges that exist can be summarised as follows:

Challenge	Blueprint Response
Challenge 1: Rapid implementation of PHM • The system will not deliver significant change without system change (through innovation and integration of services). • PHM has been signed up to by the system as the route to achieve this and needs to be closely aligned to the Leeds Plan. • Rapid progress is needed, identifying and developing the first, accelerator segment and implementing commissioning for outcomes. • Once this happens, the system can start to change. Providers have articulated their readiness for this to take place.	Chapter 3 sets out the approach to the rapid implementation of PHM
Challenge 2: System Level Changes • There is a shared vision and each organisation has its own priorities - but there is a gap between the two. • A framework is required to join and translate the work being undertaken into the context of the overarching vision and articulate the System Level Changes that are required to deliver our ambition. A potential draft Framework has been proposed (Figure ES3) and further work is required to further develop and sign-off these System Changes. • This will “bunch the thousand flowers that are blooming” and test whether these initiatives are delivering what is required and intended in the strategy and vision. This will build on provider appetite and pro-activity, clarify the role and direction of the commissioner and set the plan for going forward in the same direction - working as an aligned system.	Chapter 4 sets out the System Level Changes - the bridge between the vision and the initiatives that are being developed

Challenge 3: Leadership and Governance		
• The System Alignment process highlighted an opportunity to strengthen and develop strategic, system level leadership to drive PHM forward. • The Strategic Commissioner, System Integration Function and Providers are currently working to clarify leadership arrangements and drive this work forward, supported by an effective commissioning structure.		Chapter 5 sets out an approach for how Leadership and Governance can be clarified in order to drive progress.
Challenge 4: Evolution of the Leeds Plan		
• Through the System Alignment process, leaders from across the system articulated that neither the vision nor the three gaps/‘triple aim’ in the Leeds Plan are deliverable without system transformation. • The current workstreams within the Leeds Plan are changing to understand how they deliver against the three gaps and deliver a more integrated system and PHM. • There is a risk that work becomes pathway based and only incremental improvement is achieved so evolving the Leeds plan should be prioritised. • It has been recognised that the Leeds Plan workstreams need to be ‘matched’ so that it demonstrates that services need to be transformed at a system level such that greater change can result.		The Leeds Plan requires evolution to drive work at a greater scale, across the system - this is described in Chapter 6

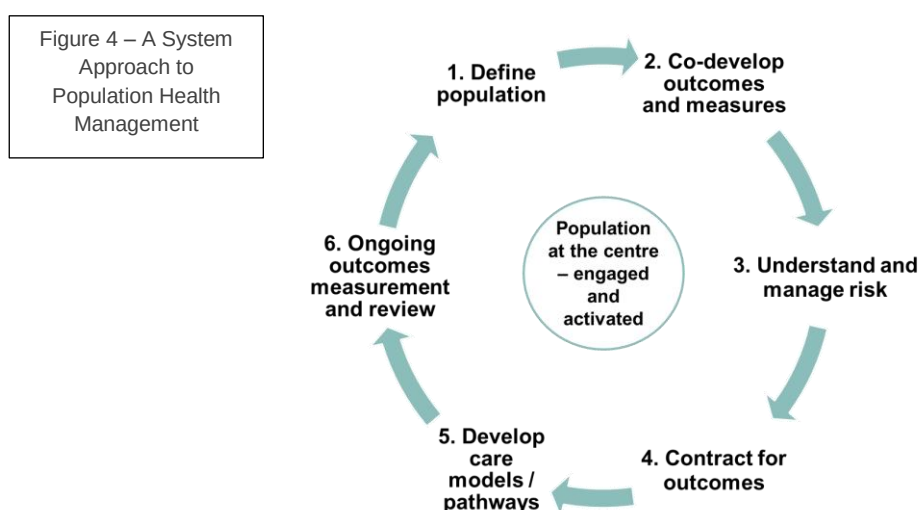
The remainder of this document therefore works through each of these four challenges, setting out how progress can be made to facilitate the delivery of the Health and Wellbeing Strategy.

3 - Challenge 1 - Rapid Progress with Population Health Management (PHM)

3.1 Ambition for PHM in Leeds

A move towards PHM is considered critical to the delivery of the Health and Wellbeing Strategy for Leeds. It provides the ability to make changes at scale, and support new ways of integrated working which may be currently limited by organisational boundaries, contracting structures or traditional pathway-by-pathway approaches.

The stated ambition for Leeds is to make rapid progress with PHM. To deliver this, PHM must underpin the whole of the Leeds Plan rather than be seen as a side issue or a separate work stream. This will enable the Leeds Plan to deliver change beyond what is possible with systems and processes as they exist now, increasing the scale, ambition and impact that is delivered.



The cycle described at Figure 4 sets out in high-level terms the system approach to PHM for Leeds and therefore summarises the actions that need rapidly take place with commissioners and providers in order to implement PHM. Citizens, patients, service users and carers will be engaged through the co-production of outcomes, development of care models and measurement of outcomes.

3.2 System Actions to Deliver PHM at Pace

As described earlier in the Blueprint, providers in Leeds have developed strong relationships and a track record of being proactive and innovative. There is a need to strengthen the direction from Strategic Commissioners to support the levels of changes required to move towards PHM.

This Blueprint proposes a combined ‘twin approach’ to take forwards PHM: harnessing the positive energy of existing progress on the ground, but aligning this to a much stronger, system-led direction of travel.

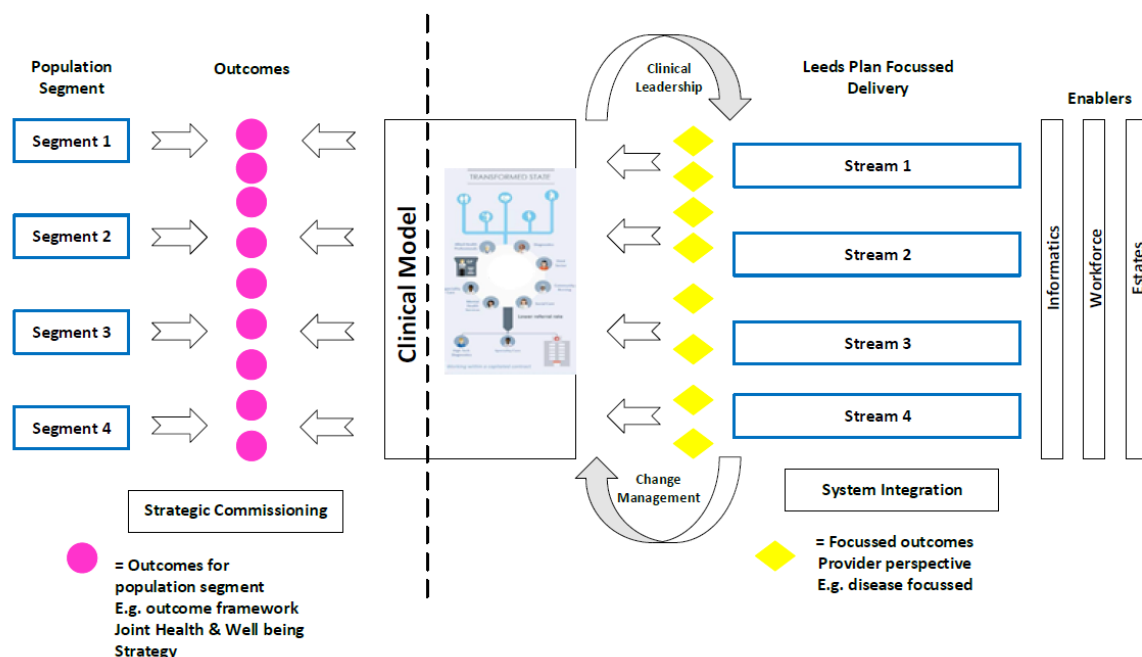
These two complementary approaches are summarised in the table below with Approach 1 adopting PHM at a system level, with Approach 2 recognising that there is positive work being undertaken in the “business as usual” commissioning and in current providers and that this must continue, despite not following a PHM approach:

Approach 1: System-Led adoption of PHM	Approach 2: Organic, Bottom-up Pathway/provider focussed
This introduces a strengthened, ‘one city’ strategic approach to PHM, allowing local teams to innovate to address the challenge of each segment	This approach continues to support provider innovation, where it is aligned to the system-led direction of travel
Steps: - Strengthen system governance and leadership to take forwards PHM and progress joint decision-making - System agreement on scope, scale and level of ambition for PHM over the short and medium term (clarifying the number and phasing of population groups, approach to budgeting (i.e. limited to health and social care or broader), time-scales etc.) - Develop and agree a system-wide approach to population segmentation (e.g. a staged approach to start with a priority macro population segment such as frailty) Align existing programmes and pilots with this city-wide approach - Agree a segment prioritisation methodology (proposed later in this chapter) Select a sub-segment(s) using the prioritisation methodology and ratify this at a system leadership group (as a commissioner and provider forum) - this becomes the “Accelerator Segment” Strategic Commissioner (LA and CCG) drives progress on outcomes-based commissioning for the Accelerator population segment(s), including: co-designing outcomes with Providers, clinicians and the public, combining budgets and working with Providers to set up population-based outcomes-based contracts over a longer period of time. - Supported by the System Integration function, providers work together to respond to the Accelerator population segment (e.g. analysis /risk stratification to identify where to maximise impact, designing service models / pathways to improve outcomes performance), and establishing appropriate financial flows and risk/gain share mechanisms to support collective accountability for performance.	Steps: Providers proactively identify opportunities for integrated care and accountable care working as a step towards accountable care - this may be smaller scale or shorter term (e.g. by single disease, pathway or with a limited number of providers). This includes tenders for GP in A&E and intermediate care beds which are currently underway and include some elements of a PHM approach - It is important to recognise that this needs to be aligned as much as possible with the system strategic priorities or it may run the risk of being unpicked in future. - Providers work together with Strategic Commissioner to progress short-term opportunities (e.g. developing bundled payments for these groups). However, in the event of insufficient resources, the city-wide system approach would take priority. - Where proposed plans do not support a move towards PHM, alternative approaches will be proposed and developed, supported by the System Integration function.

Approach 1 is summarised in Figure 5 below with the Strategic Commissioner working to define and select segments and outcomes, whilst the providers come together to develop delivery plans and the clinical model. Alone, approach 2 is unlikely to deliver true outcomes-based commissioning or wholly accountable care, however, it is the bottom-up buy-in, energy and enthusiasm that will support the move towards integration, alignment of priorities and incentives, joint working and exploring shared risk.

Figure 5 – Summary of Strategic Commissioner and System Integration Roles in PHM

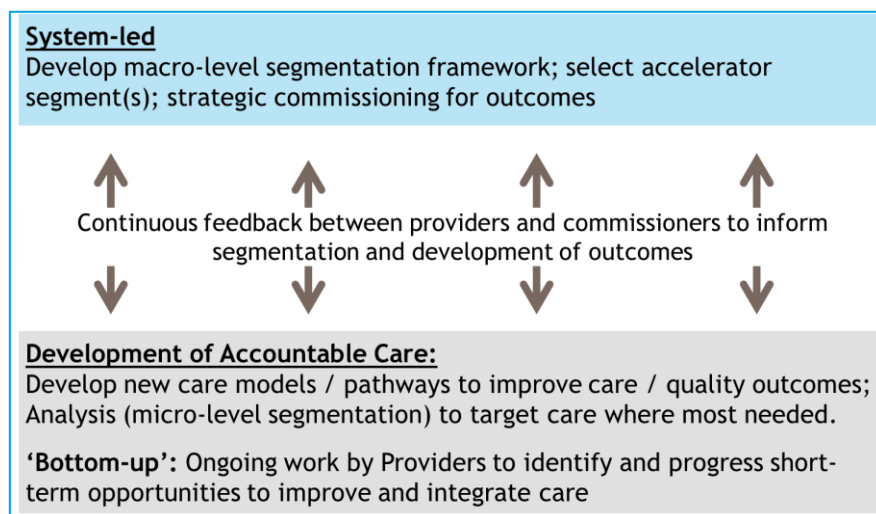
Delivery of The Leeds Plan Under PHM



3.2.1 Transition towards the System-Led Approach

The current system has, to date, been characterised by the more organic, 'bottom up' approach, alongside organisation-based service improvement activities within the Leeds Plan. This Blueprint seeks to rebalance this, with a shift over time towards stronger 'system directed' leadership, a greater role for Strategic Commissioners and closer integration of Providers. Figure 6 below summarises the interaction between the two approaches.

Figure 6 – Interaction between System-Led (Approach 1) and Bottom Up work by providers (Approach 2) in the context of population segmentation



The shift away from a pathway-based to a population-based approach is intended to increase the scale and pace of change - building on existing programmes of work in the Leeds Plan and introducing population segmentation and outcomes-based commissioning as was described in Chapter 5. A PHM Group has also been established to support this transition (see Chapter 5).

3.3 PHM Enabling Workstreams

Through the development of this Blueprint, a number of work streams have been set up to progress the technical work required to deliver the models above. This section provides a brief summary of the workstreams' progress and recommendations as well as the wider regulatory challenges and considerations associated with the progression of the direction of travel described in this Blueprint.

3.3.1 Population Segmentation Workstream

The workstream has been taken forward by CCG and Public Health leads. The aim of the work stream is to define population groupings or segments to support the move towards strategic commissioning of population outcomes. This is because outcomes are best defined for groups of people who have common needs and characteristics, rather than the current approach which segments people by pathway, service or care setting.

It has been assumed within the work stream that the relevant parts of public health, adult social care and health services are all included within the population segment.

There is no single 'right way' to do population segmentation - rather, there are a range of models that can be used for different purposes. The work stream has therefore defined three key levels of segmentation for use in Leeds as described at Figure 7.

Figure 7 – The three key levels of segmentation for use in Leeds



Segmentation Level	Purpose in Leeds	Examples
1. Macro Level “whole population segments”	- Segments the whole Leeds population into high-level, mutually exclusive segments - System focus on improving outcomes for specific population group(s) - Basis of outcomes-based commissioning, enabling providers to be accountable across the full cycle of care	- People with Frailty - People at End of Life - People with long-term conditions
2. Meso Level “sub-population segments”	Integrating care around smaller sub-segments or pathways	- Pathways e.g. respiratory - Specific conditions e.g. diabetes
3. Micro Level “cohorts” (specific populations of need e.g. geographical or high risk)	- Direct patient care/ service user level - Providers identifying specific cohorts (e.g. high needs, complexity or acuity), often using risk stratification	- Local agencies in Armley working together to support older people - Integrated Neighbourhood Team in Seacroft developing a network of support for professionals re diabetes

Recommended Approach:

A PHM approach sets out to **raise the level of ambition for the system**, by going beyond a focus on specific pathways or local cohorts to being accountable for whole population groups across the city.

The long-term ambition in Leeds is to move to ‘macro’ segmentation of the whole Leeds population. System leaders have indicated a desire for a PHM approach that is of **sufficient scale and impact** in order to accelerate the benefits of integration from existing pathway work. This takes forward Approach 1 - System Led set out in the section above.

However, as PHM is new and complex, the work stream recommends a pragmatic approach of starting with one population segment and developing learning at pace before moving onto other segments. The ambition is therefore to begin with one of the ‘macro’ segments (e.g. frailty) and use this as an initial **Accelerator segment** where rapid progress can be made.

The selection of an accelerator segment does not deprioritise or remove the need to continue the development of integration for other macro population groups or progression with the broader HWB strategy.

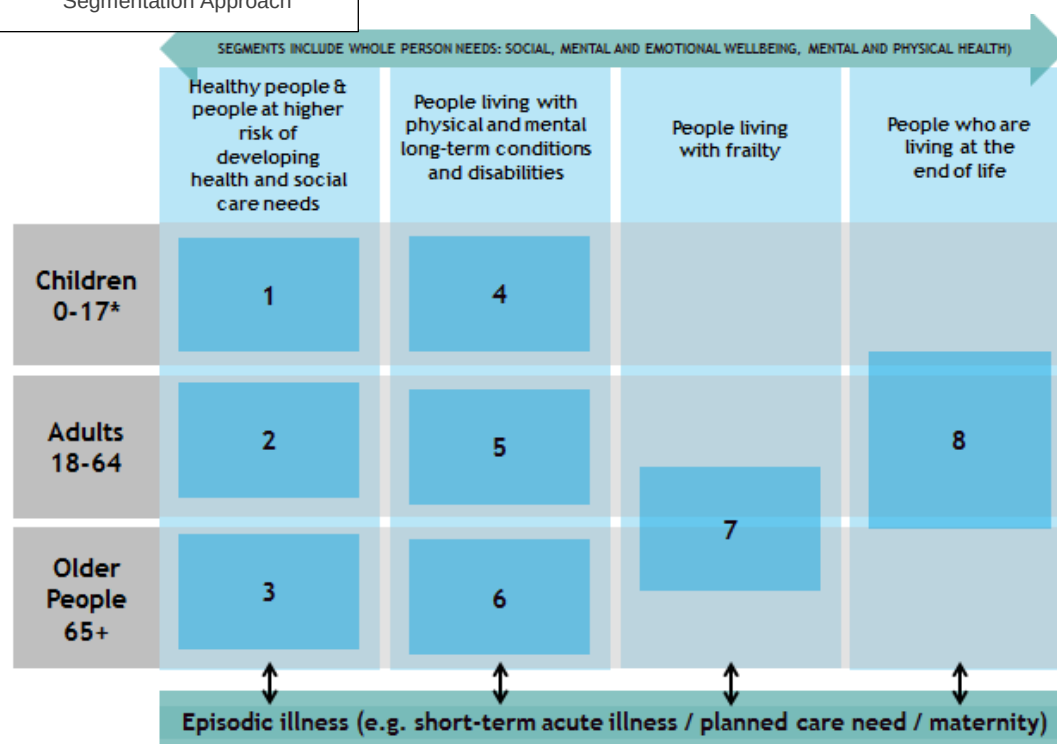
Leeds is also keen to maintain progress at a ‘meso’ and ‘micro’ sub-segment level, as per Approach 2 as described in section 3.2.1. As stated throughout this document, there is a lot of good work underway to integrate care and improve pathways for people with multiple needs, e.g. the new model of care pilots. This on-going work will continue, with consideration of how their activities are complementary to the over-arching macro-level segmentation framework which is the agreed long term approach.

Furthermore, once an initial macro-population segment, associated outcomes and agreed budget has been defined and selected by the system, it will be vital for providers to undertake local sub-segmentation and risk analysis e.g. to develop and target interventions that enable delivery of the over-arching population outcomes. For example, in order to improve outcomes for people who are frail (a macro population segment), providers will need to understand the varying needs and levels of acuity in different localities to determine where and how best to target care appropriately.

Proposed Macro-Segmentation

The work stream group has reviewed previous segmentation work in Leeds and elsewhere to develop a proposed framework for macro-population segmentation, with the whole population fitting into eight segments as shown in figure 8 below.

Figure 8 – Proposed Macro-Segmentation Approach



To note:

- The model focuses on ‘the whole person’ at all times, and recognises that people’s broad needs and priorities for their health and wellbeing will change according to their general life stage or health status.

- All population segments contain a range of acuity and will include people who are generally healthy and independent, meaning the 'Healthy' segment represents 'all other'.
- It has been assumed that public health, adult social care and health budgets are all in scope.
- **This is a proposed model and will undergo further engagement** with key stakeholders as set out in the

Selecting the Accelerator Population Segment

There are various suggestions in Leeds for which segment should be chosen as the initial accelerator with which to test the new approach. The work stream has developed a methodology and key criteria to support this decision. The approach recognises that there is no 'perfect' data-driven answer, as some of this information will be incomplete or unavailable since current reporting is not aligned to population segments. The intention is to use existing data be pragmatic and fast-paced, and to provide transparency and confidence in the final decision of the Strategic Commissioners. Proposed selection criteria for the initial accelerator segment are summarised in the table below:

Segment selection criteria and example methodology	
Step 1: Assess against 3 'gaps' described in Leeds vision to develop shortlist (<i>N.B. Services or conditions will need to be translated into a macro population segment</i>)	
#1 Health Outcomes / Inequalities	Assess poorest performing indicators and highest contribution to health inequalities
#2 Cost to System (Leeds £)	Identify highest cost to the system (current spend, future spend, opportunities for spend reduction)
#3 Quality Gap	Where available, identify areas across the system that are known to be poor quality or unsafe e.g. lack of resource or clinical effectiveness, workforce, patient experience
Step 2: Take shortlisted population segments from step 1 and assess their alignment with strategic plans, system impact and long-term population health	
#4 Strategic Alignment	Alignment with STP, HWBS and Leeds Plan; Fit with ambition for PHM and commissioning for outcomes; Political acceptability
#5 Scale of Ambition	Extent that selected segment will create the desired impact to achieve sufficient system outcomes to meet the scale of the challenge (financial and clinical) Ability to incentivise or encourage accountable care or improve coordination of care across providers (i.e. at appropriate scale)
#6 Long-term impact on population health	Opportunity to significantly move care upstream, prevent onset or exacerbation of clinical conditions, reduce demand and/or sustain health and wellbeing in the future
Step 3: System discussion (Provider-informed) about how best to impact chosen segment e.g. new care models etc.	

The Roadmap and following section on outcomes describe the key next steps to be progressed once the initial accelerator segment has been identified and confirmed.

3.3.2 Commissioning for Population Outcomes Workstream

System leaders have confirmed the ambition for Leeds to move towards commissioning for population outcomes. A workstream has been established to scope and articulate what this means in more detail.

Commissioning teams are currently moving away from incremental pathway by pathway redesign towards a more collective approach with provider alliances, longer contracts and consideration of outcomes for services. This represents a positive step on the journey towards a more end-to-end person-centred approach of commissioning for population segments and outcomes.

At the same time, Strategic Commissioners recognise there is still a considerable step change required in the culture, ways of working and skills needed to commission for population outcomes, which will have a fundamental impact on the future roles of and relationship between Commissioners and Providers (see Section 7).

On-going development is therefore required in order to generate momentum in order to **keep pace with provider ambitions** and meet the commitment to implement PHM at **scale and pace**. This development will be underpinned by several key principles:

- Working collaboratively and transparently with integrated Providers and System Integration function throughout
- Closer working between CCG and local authority commissioning teams
- Maintaining focus and alignment with the strategic vision e.g. addressing prevention and inequalities
- Co-producing outcomes with health and care commissioners, providers, clinicians, third sector and people/citizens
- Considering the interests of smaller providers in the city
- Reducing ‘unnecessary’ burden on providers where possible e.g. non value-adding
- Maintaining national or regulatory requirements of quality and safety, and working together as a system to escalate where these do not meet the needs of Leeds
- Recognising the opportunity to align outcomes and associated measures across Leeds and across the wider West Yorkshire and Harrogate footprint.

The work stream has so far defined several broad ‘intentions’ for **Strategic Commissioning** to support the system ambition of PHM:

- To lead the **development of a set of outcomes** for the initial accelerator population segment, focusing on a manageable number of outcomes e.g. 5-10 per segment (the approach to this is set out in more detail in Chapter 6).
- To commit to **longer-term contracts** at sufficient scale (e.g. 5+ years) in order to give Providers confidence and sustainability.
- To establish a new approach to accountability for clinical, financial and reputational risks between providers as a collective and also across commissioners and providers.

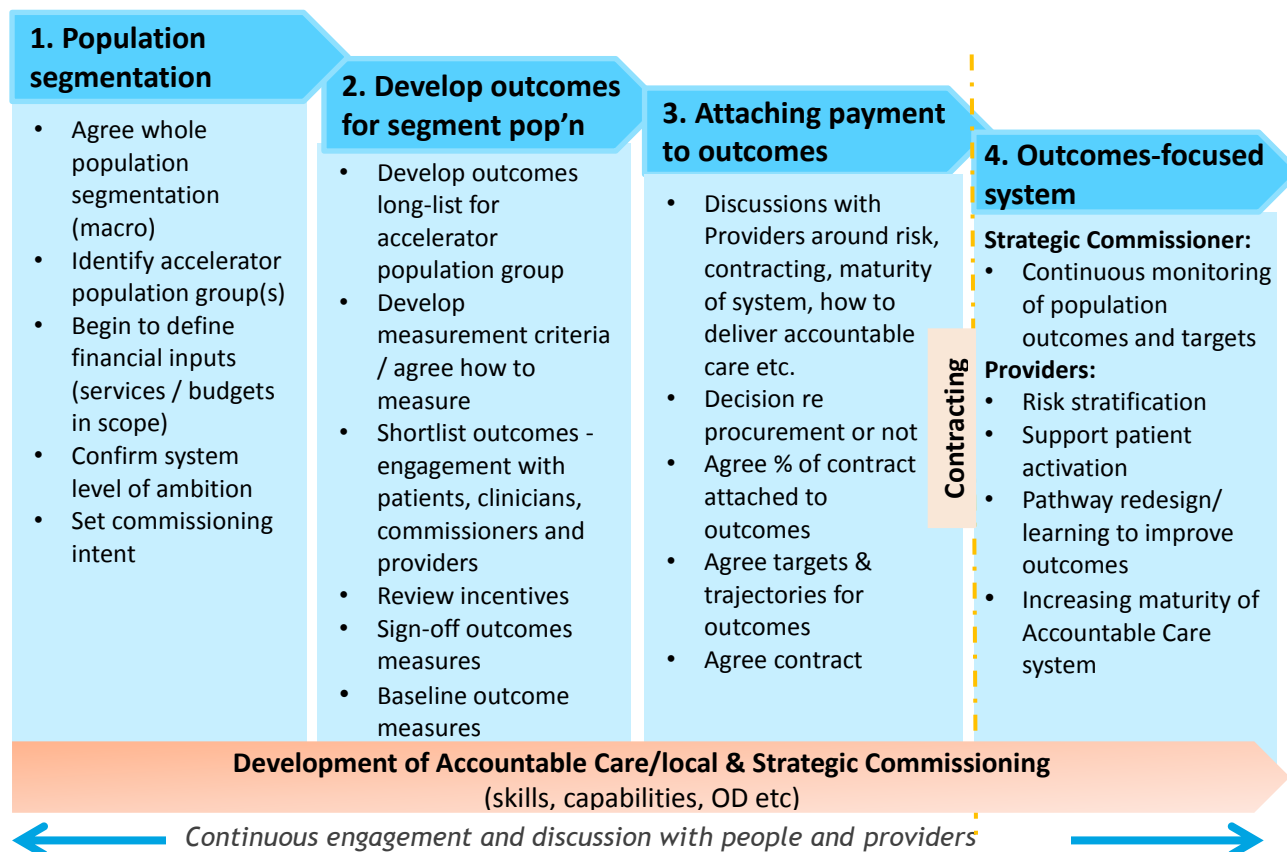
- To put in place live contracts for the initial accelerator population segment/s by **April 2019** (see Finance and Contracting section in Chapter 6). This represents a commitment to move at pace, although this speed will be dependent on the level of collaboration between and with Providers and the maturity of integrated or accountable provision to take on these contracts.
- Recognising the current legislative environment, the explicit assumption is that these contracts will be a collaborative system approach, **going out to market via procurement as a last resort**. To support this, the system will need to be clear of regulatory support to enable this as well as associated regulatory challenge and risk.
- To implement **shadow outcomes** and align incentives / remove barriers as soon as possible to enable new care models to take shape i.e. create the appropriate commissioning and contracting environment for Provider collaboration.
- To **reduce or halt overtime**, activities or reporting requirements where these are not aligned to a population/outcomes approach, and where this reduces the burden on Providers.
- To **upskill** the commissioning workforce (including finance, contracting and cultural change) to support the new ways of working required. An initial set of education workshops is already underway to raise understanding and awareness.
- Alongside work on the accelerator segment, to identify how existing working/business as usual (BAU) is aligned to the macro-segmentation framework and continue to support greater integration of pathways and services as per the principles of PHM.

Commissioning for Outcomes: high-level stages

Population segmentation is not an end in itself - it is an enabler and prerequisite for outcomes-based commissioning and accountable care. Outcomes will be developed for the chosen macro population segment/s, supported by changes in finance and contracting, such as a single, capitated block contract for each macro population segment. In turn, providers will be jointly accountable for population groups across a range of care settings, and will have greater autonomy and flexibility to develop new pathways and models of care to improve population outcomes and increase efficiencies across the system.

Figure 9 below sets out the broad steps on the journey towards outcomes-based commissioning. Next steps are set out in more detail in Appendix A (the programme plan):

Figure 9 – Broad Steps towards Outcome Based Commissioning



The move to a population health management approach in an accountable care system is a fundamental change to traditional commissioning and service provision. As part of the process it is important that all risks need to be identified and understood by system players so that collaborative solutions can be developed to minimise risks at both a system and organisational level. This will include clinical, financial and reputational risks. Agreeing principles around risk share arrangements should be made at an early stage to provide assurance and commitment to developing the PHM approach.

Chapter 7 describes how the roles and responsibilities of each organisation in the system will change as a result of outcome-based commissioning.

3.3.3 Finance Workstream

In moving towards a PHM approach we are working within a finite financial envelope across the health and care system. Whilst it is recognised that Leeds will initially progress an initial 'accelerator' population segment, it is essential that our starting point must be to map and allocate the totality of resources and finances across all population segments from the outset. This should ensure that the sum of the budget for each segment always balances back to the total resources available. It should also enable commissioners and

providers to identify potential financial risks at an early stage, thereby maximising the opportunity to put in place suitable mitigating actions to maintain the financial stability of individual organisations and the system as a whole. Not taking this approach risks an inequitable distribution of resources across population segments resulting in the inability to deliver the desired outcomes for all population segments.

The finance work stream has developed, through working with finance leads from across Leeds, a summary of both appetite and key concerns in relation to PHM, and discussion of solutions and approaches based upon best practice from elsewhere.

The involvement and commitment of local finance leaders to the move toward PHM (outcome based commissioning and accountable care) is clearly critical to making rapid progress. The work discussed with leaders from each organisation across Leeds provides a strong foundation for taking this work forward in more detail. Indeed, finance leaders are keen to see changes take hold and make a difference in the short term, providing a key solution to the financial challenges that face organisations across the city. Workable options will need to be discussed at a high level, together with their potential risks, mitigations, challenges and opportunities.

3.3.4 Regulatory Challenges and Considerations

This Blueprint articulates a move towards PHM, and within this strategic commissioning for outcomes and integrated delivery through accountable care arrangements. A key challenge, both locally and nationally, is the complexities of current legislation, each of which has developed to ‘solve’ a different challenge. Consequently, the current legislative and regulatory environment is designed to reflect traditional approaches to commissioning and contracting and presents potential challenges to this new approach to commissioning and accountable care provision as described in this Blueprint.

In moving forward there is a need to balance the requirements of the UK Public Contracts Regulations (PCR) including full market assessments and engagement; NHS (Procurement, Patient Choice and Competition)(No2) regulations; and the Cities and Local Government Devolution Act 2016. Recognising this, our starting point must be to understand and be clear about what it is we are trying to achieve and designing the procurement and contracting approach(es) around those objectives.

Other key significant areas include consideration of appropriate contractual form. National guidance is that new care models must be contracted on the basis of one of the New NHSE standard contracts (currently being tested by Vanguard sites). There is a need to have identified the most appropriate contract format including the approach to GP Primary care contracting, in advance of commencing market engagement.

Recognising lessons learned from the collapse of the Cambridge Uniting Care Partnership (UCP) financial modelling to understand the impact and implications of tax, TUPE and VAT on commissioners and providers must be undertaken. Again, it is important not to underestimate the time capacity required to undertake this essential exercise. Within this, contractual, managerial and legal liabilities must also be defined at organisational and individual level. A summary of the key challenges posed by the regulatory environment to establishing a PHM approach is provided at Figure 10.

Figure 10 – Key regulatory considerations and challenges associated with establishing a PHM approach,



External assurance for establishing a PHM approach in Leeds and commissioning and provision of outcomes for the initial accelerator segment will be managed through the Integrated Support and Assurance process (ISAP). The ISAP is the NHSE/NHSi external ‘gateway’ process which must be used to provide assurance in relation to any complex (including ACS and ACO) contracts. The ISAP is extremely comprehensive and learning from other national health and care systems highlights the importance of factoring sufficient programme time and capacity to ensure full compliance with all elements of the framework.

The initial ISAP gateway focusses on early engagement. The early development and implementation of a full Stakeholder Communication and Engagement plan including market engagement and market assessment is of paramount importance. The Roadmap will be iterated and updated to reflect the full requirements (and associated timescales) of the ISAP.

3.3.5 Data Workstream

In order to support PHM being taken forward rapidly, the availability of linked data across health and social care is crucial. Leeds has made significant progress in this regard over recent years and has developed the Leeds Data Model [LDM], a linked data set across several care settings.

To ascertain whether the Leeds Data Model in its current form could be used successfully for the type of segmentation and outcome approach that has been described above, it was tested against a number of exemplar outcomes that had previously been identified. The system metrics were tested to identify specific health outcomes for specific patient and service user populations.

It was concluded that, from a technical point of view, the system was able to run these queries successfully and was therefore deemed fit for purpose in supporting a move to PHM. This is highly positive and provides a key enabler to take this work forward.

However, a number of further factors will need to be considered. Amongst these are; is the data refresh cycle of the LDM adequate and which risk stratification algorithm/s should be used within the LDM?

There are also some broader technology considerations required to support an integrated care provision and strategic commissioning. Leeds needs to continue to work towards its integrated technology strategy. This includes common networks and common wifi access, to allow staff to work from all public buildings and in a mobile fashion. Integrated systems are required to support integrated care such as the Leeds Care Record, a direct patient care facility that brings together clinical information from across 5 care sectors. Work should continue to ensure a digitally literate workforce and digitally connected citizens.

3.4 Recommendations from this Challenge/Chapter

There has been a clear steer from City Leaders, through the system alignment process that providers are keen to make progress on responding to commissioner priorities once these have been clarified. Therefore, there needs to be rapid progress to lead the development and adoption of PHM as the system's approach to commissioning. The challenge laid down by the system is to stop focussing on problems that arise from traditional contracting and to focus on developing and implementing a new system that offers providers the freedom to innovate within the System Challenges proposed above. To support this, a comprehensive understanding of the current regulatory environment, associated challenges and learning from other health and care systems is essential.

Key recommendations are therefore to:

- Make rapid progress with the macro segmentation work and identify an initial accelerator population segment.
- Develop outcomes and identify budgets for this macro segment.
- Ensure any relevant work at a micro or meso segmentation level is consistent with the macro segmentation approach and incorporated where appropriate .
- Recognise the salience and time taken to support local relationship building and cultural change as key elements delivering new approaches and interventions at micro segmentation level.
- Work closely with finance and contracting teams to understand and manage financial risk, explore new approaches to contracting within the context of the wider regulatory environment.
- Identify resource to support this move to PHM, identifying commissioning and contracting activities which can be stopped in order to free-up resource to develop and implement this new approach.
- Continue engagement at a system level between commissioners and providers to ensure that the relationships exist in order to take this work forward.
- Ensure sufficient time and capacity is allocated to provide full external assurance to local stakeholders and externally to NHSE/NHSI through the ISAP.

4 - Challenge 2 - System-Level Changes

This section sets out the changes that are required at a strategic, system level in order to deliver the vision for Leeds.

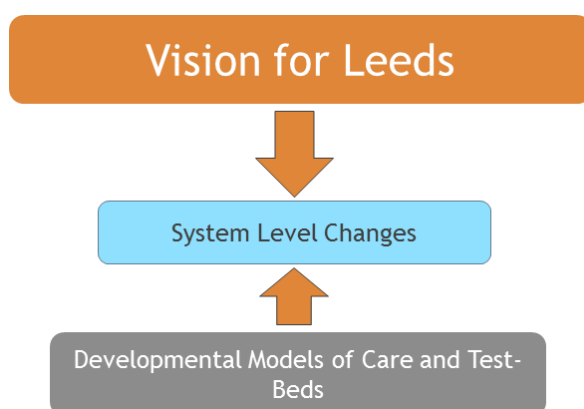
As stated above and highlighted during the system alignment process, there is a clear need to clarify how the range of activities being undertaken on the ground (e.g. Leeds plan workstreams, New Models of Care test beds etc) will help to deliver the system level changes needed and the vision for Leeds.

As the Leeds Plan workstreams develop they will be able to more accurately articulate the system level impacts of their planned activities. The changes proposed within this document can then be taken into consideration, once gaps have been identified.

4.1 Introduction to the Suggested System Level Changes

There are currently a number of provider-led and pathway focussed workstreams underway. However for the overarching vision for Leeds to be achieved and the three gaps or 'triple aim' addressed, this will require **system level changes** to be agreed (see Figure 11 below).

Figure 11 - System Level Changes Fill the Gap between the Vision and Models of Care



Once agreed, these system level changes can be used to allow commissioners and providers to test both the work underway and future activity to ensure that it is consistent with the system wide vision and aims. These changes will also acts as a framework in order to:

- Support commissioners and providers to develop their work in line with a set of strategic and system level aims and objectives.
- Identify any gaps in scale and impact which mean that the work currently planned and underway will be insufficient to deliver against the system aims
- Support development of work at a population segment and a pathway level to address these gaps.

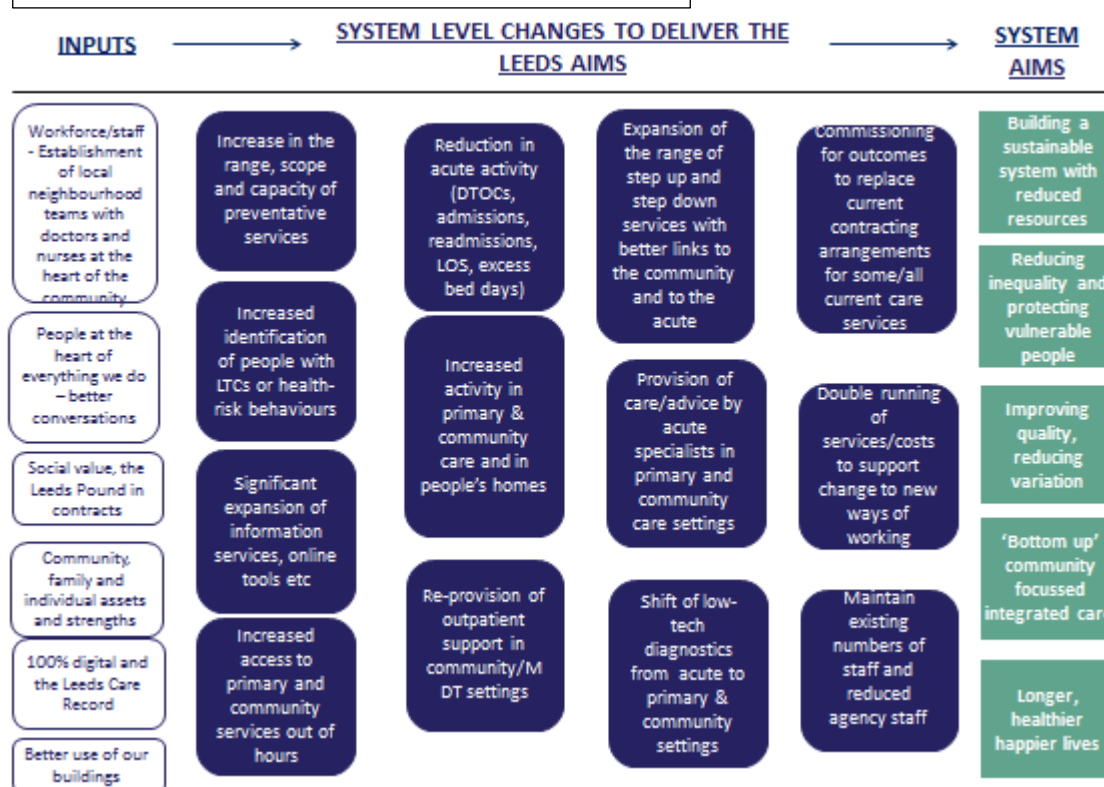
In a perfect system this work would take place before activities and processes were developed, however it is clear that there is a task to test / learn, include and align all the projects and programmes currently underway as part of commissioner- and provider-led work, as well as that future work planned within population segments.

4.2 Proposed System Level Changes

To bridge the aforementioned gaps between system aims and work on the ground there is a need as a system to articulate our system aims. Figure 12 below proposes a **suggested framework** for bridging this gap and sets out:

- The high level system aims encompassing the three gaps or ‘triple aim’ as well as the HWB strategy outcome relating to health and care;
- The **system level changes** that will contribute to the delivery of the aims:

Figure 12 – Draft System Level Change Framework



It is important to note that one system level change may contribute to a number of aims - for example, increasing preventative services contributes to both healthier lives and to system sustainability in the long term.

It will be important to be able to articulate how work underway already will deliver some of these high level impacts and therefore how they are contributing to the delivery of one or more of Leeds' system aims. This includes the Leeds Plan work stream actions and New Models of Care test beds.

4.3 Further Development of the System Level Changes

The need for the adoption of this approach was described by leaders throughout the system alignment work, and the draft version above has been shared with groups such as the Integrated Commissioning Executive (ICE) and Population Health Management Group (PHM). It has been agreed that further development of this approach over time is required in order for the system to move together towards solutions which directly support the aims and objectives of the Health and Wellbeing Strategy. With providers and commissioners aligned around more than a vision - i.e. a series of system level changes and impacts - this will drive work at a greater scale, clarify the “ask” from providers, provide clear direction to the business as usual service and pathway improvement work that is underway.

It is recommended that, once the system level changes are agreed, further work is carried out to:

1. Set the scale of ambition for each system level change.
2. Work to identify the potential financial, workforce and activity implications for each change and set out level of ambition.
3. Logic models to link the activities and processes to the system level changes and the system aims. This will also allow Leeds to clearly articulate how its workstreams and plans are contributing to the high level changes that are needed to deliver the system aims.

For example, if it is agreed that the system needs to deliver a system level change around ‘Reduction in acute activity’ (Delayed Transfers of Care (DTOCs), admissions, readmissions, Length of Stay (LOS), excess bed days), it will be important to set out:

1. The scale of ambition (e.g. how many admissions will be avoided - 10% or 40%);
2. The implications for finances (x% of admissions avoidance will lead to a £y saving to the system);
3. Which activities will deliver the reduction needed (e.g. new neighbourhood teams will provide increased MDTs for people with complex needs to prevent avoidable admissions).

The financial implications of the system level changes that will result from a long-term, system-wide service delivery redesign are likely to be:

1. Reduced non-specialist activity and income for Leeds Teaching Hospitals Trust (LTHT), facilitating a reduction in fixed and variable costs;
2. Increased activity, income and cost for community, mental health and primary care providers; and
3. The use of new contracting methods - commissioning for outcomes - to replace current contracting arrangements for some/all current Leeds care services to enable the achievement of both system outcomes (greater alignment and integration) and health and care outcomes.

The impacts of these will be financially material to all organisations and will need careful consideration as the contracting approach is developed further.

4.4 Recommendations from this Challenge/Chapter:

- System Leaders (PEG/ICE and others) to agree the system level changes needed to deliver the Leeds vision.
- System leaders commit to system changes to ensure current and future change activity articulates how it will be directly contributing to the delivery of one or more system level changes. For example: the “Improving secondary care work stream of the Leeds Plan will deliver a reduction in acute activity by improving the efficiency within the acute trust”.
- Carry out further exploration, in the short-term, to explore potential contractual options and commissioner and provider perspectives on the options as well as risk/gain share options.
- Ensure early, on-going and continued involvement of the finance leaders in this work as it progresses.

5 - Challenge 3 - System Leadership and Governance to take forward Population Health Management

5.1 System Leadership

The system alignment work provided a strong message that the development of integrated provision and strategic commissioning for outcomes can only be achieved through strong leadership. The summary below sets out how this is currently perceived and provides context for the recommendations made later within this chapter:

Leadership of and within organisations is effective and strong. Often this can drive significant change and improvement within organisational boundaries - for example the changes associated with ‘One Voice’ for the CCGs and the implementation of the “Virginia Mason/Leeds Improvement Methodology” quality improvement approach in LTHT. Good progress has been made on a range of areas such as setting up a single care record, world leading cancer care, children’s voice and effective use of community assets, including social prescribing and third sector working.

Good cross-partnership engagement and the right discussions are taking place; however, leaders have reported that there is some lack of clarity or ambition to address the scale of the financial and demographic challenges.

It was felt by many leaders that in order for Leeds to deliver its **health and wellbeing** vision for its citizens, joint and system level leadership must be strengthened to provide more strategic direction to the system. This will provide assurance to the system that the city’s plans are delivering the vision for its residents.

This should be supported by the excellent **linked data** the city is renowned for and should be used to undertake analysis and drive the segmentation work to join up care for better patient/citizen outcomes. This will support the Leeds Health and Wellbeing Strategy ambitions to deliver care to those in greatest need across our health and care system.

An incremental, bottom-up 'business as usual' approach to improvement through existing organisational structures is what is recognised and thereby, the city is noted to have strong foundations within the locality/neighbourhood teams. There is a great opportunity to build further upon these to develop **local care partnerships at local level**.

It is also recognised that **statutory organisations are unlikely, in the short term, to devolve all authority to a single city body**, so Leeds should strengthen the already positive Leeds partnership ethos, strengthen existing groups and formalise decision making to ensure decisions made are binding.

The **Leeds Health and Care Partnership Executive Group (PEG)** remains central to the city. The PEG should ensure it enhances its role to do more to visibly demonstrate the partnership voice and sharing of partnership messages and behaviours within organisations.

A **citywide PHM group** has now been established. This is an opportunity for both providers and commissioners to come together to plan service future developments and agree key outcomes between providers and commissioners and provide a steer and ongoing work undertaken on outcomes segmentation and finance. There is an opportunity that the group provides a key more operational interface between commissioners setting outcomes and providers designing implementation delivery models.

Commissioning

There is an opportunity to **strengthen current commissioning arrangements** in the city to enable outcomes commissioning to facilitate integrated care.

The **Integrated Commissioning Executive (ICE)** currently has a more narrow focus. In the light of commissioning moving towards more strategic outcomes, it has an opportunity to review its focus and breadth which could expand over time and, for example, should a focus on frailty be agreed consider more joined up older people's commissioning between health and social care partners. The ICE is crucial to have the oversight of investments and disinvestments made within its current remit or how this has expanded to include older people health care commissioning.

It is acknowledged that the role of ICE could be expanded over time to support more **joined up commissioning with the Local Authority**. Likewise, the commissioner and provider partnership would support the conversations around Population Health Management.

Providers

It was recognised that there is good **clinical leadership** in Leeds with effective driving of innovation - however this is often bottom up which can lead to potential misalignment between initiatives on the ground and the strategic priorities for the city. There is an opportunity to revisit citywide strategic clinical leadership through the clinical forum discussions; sometimes best practice has been hard to scale up across Leeds.

Providers are coming together in terms of new working relationships and it was noted that **Alliance working has commenced**. It was recognised Leeds has taken the first bold steps to become more strategic and outcome focused and integrated with the local authority.

Delivering the **neighbourhood model** is articulated in the Leeds Plan refresh as a priority across the work programmes. More work is noted to be ongoing to translate these into actions and whole system changes.

Focus around **children and the family** is recognised within the Leeds Plan refresh and it is important to make this link between adults, families and children in the delivery models within localities. Many children’s services are delivered through 25 school clusters and there is an opportunity to review and align this geography with the primary care neighbourhood model.

The **Provider Network** was recognised as a firm network to support provider collaboration and to manage and sign off plans for integrated working. It was noted to have a longer term aim to move to an Accountable Care System or partnership to develop associated agreements such as MOUs and risk/gain sharing understanding. In the light of the Leeds CCG Board being the “Commissioning Strategy and System Integration Board” it should consider renaming this to the Accountable Care Partnership Board to reduce confusion.

Figure 13 below proposes a potential relationship map:

Figure 13 – Proposed Relationship Map



5.2 Culture and Behaviours

During the system alignment review process it was highlighted by some leaders that there is a legacy of mistrust between the organisations in the system, there are a number of areas where relationships are strong which should be built upon. The move to one commissioning organisation and ‘One Voice’ work is positive though it will require on-going work to embed this approach. The forming of the provider alliance/partnership approach is also very positive in building a culture for collaboration.

Another key finding is that the scale of the organisational development challenge has been underestimated - there is an assumption that simply putting frontline teams together will lead to integration. So, it will be important to further build upon the asset-based/strength-based work in social care and the health coaching work in healthcare.

It is critical that a new relationship is formed across the system between commissioners and providers, as the move towards PHM and away from Payment by Results takes hold. **It will not be possible to maintain the same contracting relationships and deliver against the approach set out in this Blueprint.** A set of design principles have been suggested which will guide the work going forward and build upon the relationships that exist across Leeds. These include:

- Whatever we do, we do city-first, place-first.
- Wherever possible, we should simplify, standardise and share.
- Strong leadership with clear governance and sign off and joint ownership of benefits realisation.
- Good is good enough - don't let perfection get in the way. Use an iterative approach to build and see where we get to.
- Asset based approaches.
- Change management approach.
- Engagement throughout especially with Leeds residents
- Clinically led.
- Co-produced with providers - at operational level and at leadership level
- Evidence based.
- Robust process with clear audit trail of decisions made and reasons why
- Adopt digital.
- Not sending out inconsistent messages such as carrying out rigid procurements. Whilst at the same time expecting provider and commissioner collaboration on the ACS/AC Partnership.

As these principles are amended, added to and adhered to it is expected that this will support the adoption of a new relationship across the system, building upon existing positivity to enable and facilitate the move to PHM.

5.3 Recommendations from this Challenge/Chapter

- Strengthen governance - including as part of this a review of the system changes proposed in Chapter 3, and also the design principles for the programme going forward.
- Enhancing the capability and capacity of the system leaders through leadership development of the system leaders together. This will help them further develop their skills to really drive system change and to influence regulators, etc.
- Socialising the Blueprint, leading discussions with providers to gain sign-off for the work going forward.
- Continuing to develop the current role of the commissioner into strategic commissioner and system integration - following the change in roles set out later in this Blueprint.
- To develop an Organisational Development plan to support and implement new ways of working, culture and behaviours.

6 - Challenge 4 Evolution of the Leeds Plan

6.1 Using the Leeds Plan to Provide a Foundation for Population Health Management

As highlighted by leaders during the system alignment process the current workstreams of the Leeds Plan will not enable delivery of the Leeds Plan aims and objectives or the establishment of PHM across Leeds. There is an opportunity to review the Leeds Plan in the light of this to ensure that the workstreams articulate a system view with the scale to deliver the challenges set out in the Health and Wellbeing Strategy, the vision for the city and the three gaps or 'triple aim'.

As was stated above, to succeed and achieve against these challenges, Leeds has to simultaneously balance the need to:

1. Continue to deliver pathway level re-design and make the city more resilient.
2. Actively establish a PHM approach by commissioning for outcomes for a defined population segment and establishing accountable care arrangements between providers to deliver these outcomes

The approach below proposes how, within the context of the Strategic Commissioner and System Integration functions and the Leeds Plan, Leeds can achieve these three system needs.

Figure 14 below shows the four workstreams of the Leeds Plan with the on-going service redesign work within each column. The lower part of the diagram introduces how the selection of a population segment with which to make progress would impact on workstreams:

Figure 14 – Impact of Segment upon Leeds Plan Workstreams

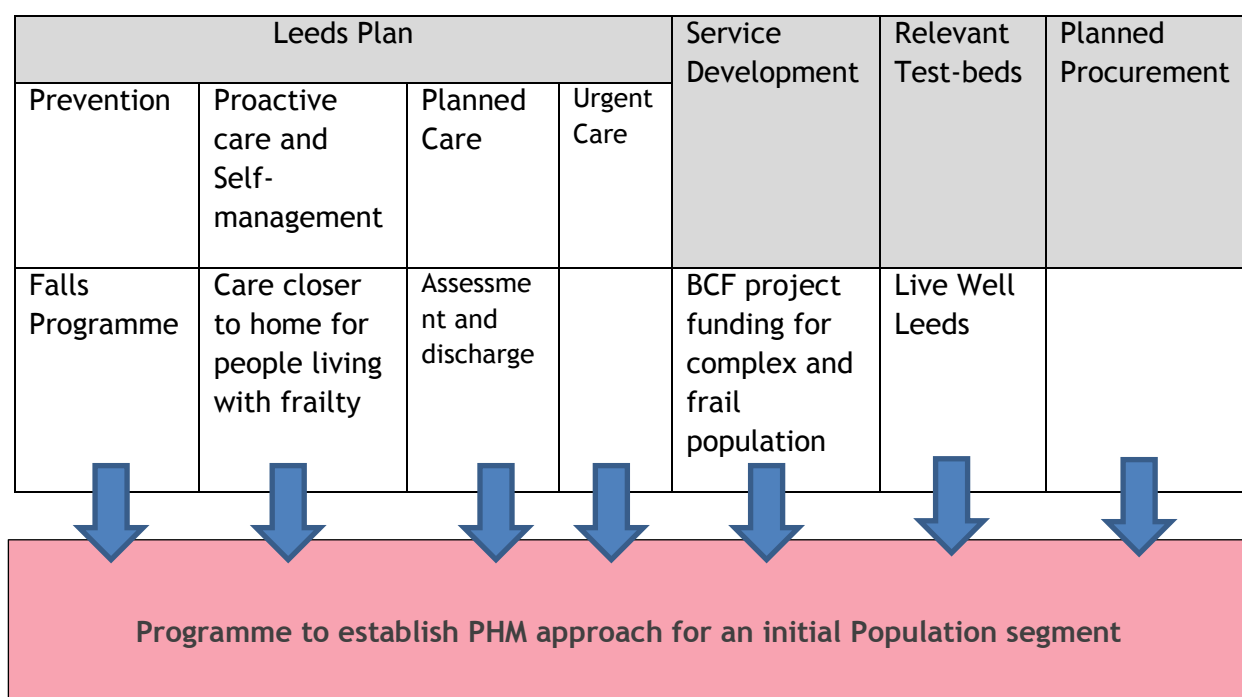


Within this approach, Leeds establishes a population based approach to commissioning and provision of outcomes for an initial, substantial, population segment while simultaneously continuing to deliver priority pathways as part of on-going Leeds Plan work. As part of this, pathway, service redesign and procurement plans related to the delivery of outcomes for the initial population segment would be paused and transfer into the work programme supporting delivery of outcomes for the initial population segment.

In practice it is assumed that once the priority segment has been identified by the system the System Integration function will work to subsume the existing work into the provider side response for the segment.

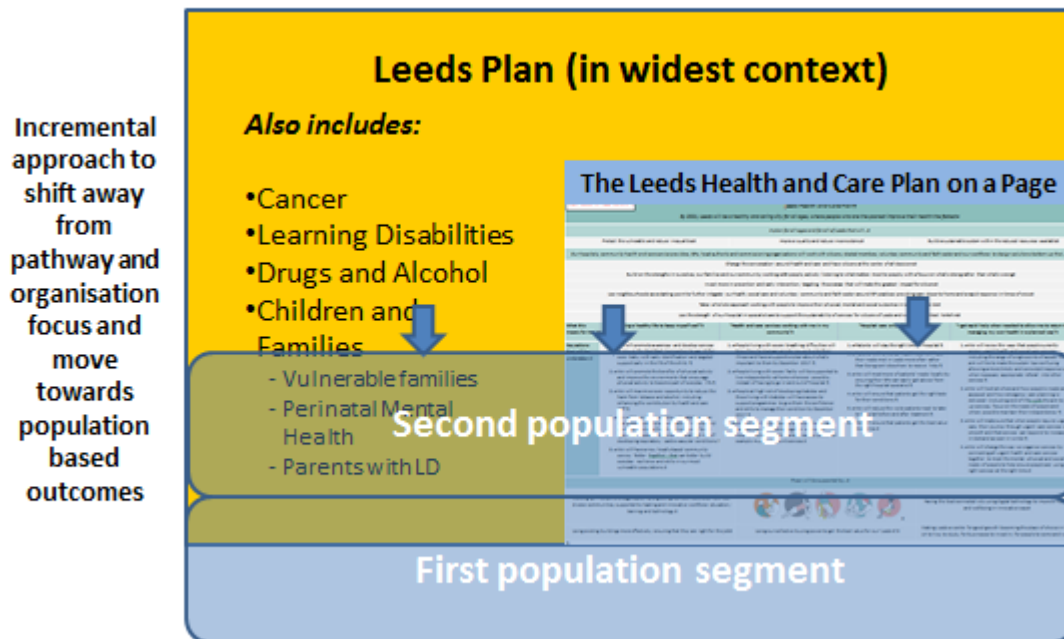
Purely by way of example, if Leeds chose the >65 population as its initial population segment for PHM, the following areas of service re-design, models of care and Leeds Plan deliverables would be subsumed into the programme. This scenario is depicted as an example in Figure 15 below:

Figure 15 – Example of how existing work would be subsumed into work at a segment level



Over time it is anticipated that the whole system will ‘flip’ from commissioning pathway based approaches to commissioning outcomes for population segments. This would occur by incrementally with increasing new population segments, as demonstrated in Figure 14 below.

Figure 14 – Moving towards additional segments



It is intended that this approach means that the Leeds Plan on-going work can be continued, population segmentation can begin in earnest, and the two tasks can complement each other. Of course, as described throughout this document the PHM approach will increase the scale of the work and encourage a system wide approach, in effect augmenting the Leeds Plan work that is already underway.

It is recognised that there are risks with adopting this approach and these are set out in Chapter 8, however, without linking the Leeds Plan with PHM it is likely that:

- The current workstreams of the Leeds Plan will not deliver the ambitions and aims of the Leeds Plan as this is dependent upon transformation of the system and on the changing of incentives across providers to really drive benefits
- The changes driven from the Leeds Plan become incremental rather than material (when compared with the scale of the financial gap)
- PHM will not be implemented and provider integration will be far less significant than expected and required.

6.2 Recommendations from this challenge/chapter

- System Leaders (PEG/ICE and others) to agree the proposed approach to future working:
 - o Reviewing on-going work within workstreams (in the context of the system level changes set out earlier in this document) to ensure it is consistent with the move to PHM, and stopping/adjusting the work where it is inconsistent.
 - o Updating and linking the system level changes with the Leeds Plan by establishing the delivery of the first accelerator population segment as the overarching programme within the Leeds Plan.

- Advising the HWB and Leeds Plan Delivery Group that a pathway segment will likely be selected in the short-term and that this will affect each of the workstreams - this can be planned in advance based upon the likely segment.
- Agreeing a set of principles to influence the delivery of the four Leeds Plan programmes to ensure that the service developments within these reflect the ambitions and aims of the Leeds Plan and a wider PHM approach. This will facilitate seamless transition into future population segments.
- Strengthening the management and governance of the Leeds Plan to take into account these changes.
- Updating all internal and external stakeholders (including the public) in relation to the evolution of the Leeds Plan, identifying the change in scope, scale, pace and transformational nature of the work planned.

7 - Organisational Impact of moving towards Population Health Management and delivering this Blueprint

This document has provided a set of recommendations regarding how the system should respond to the four key challenges associated with the delivery of a PHM approach in Leeds:

- Rapid progress towards Population Health Management;
- Clarity of system-level changes needed in order to deliver the system vision;
- Leadership and commissioning arrangements to drive system level changes; and
- Evolution of the Leeds Plan to support PHM and increase scale of ambition.

The impact on individual organisations of delivering the Blueprint and establishing a PHM approach should not be underestimated. To succeed, it is essential that all organisations understand, own and are prepared to make the necessary organisational, cultural and financial changes required. The following section describes a high-level summary of the impact of these changes upon commissioning and provider organisations across Leeds.

7.1 Impact on Commissioners and Providers

Figure 17 below depicts how strategic outcomes for an initial population segment (shown below as adults with long-term conditions) would be agreed, along with an agreed budget and timescale for delivery (blue section of triangle below). The role of the strategic commissioner is to ensure delivery of these outcomes. Responsibility for the activities below the blue triangle are those of the accountable care system/organisation. A key task of the accountable care structure is to use qualitative and quantitative data and insight to identify, prioritise and plan 'meso-level' areas of focus that will have the greatest impact on achieving the strategic outcomes set by the commissioner. This could include identifying planning citywide approaches with sub-populations at highest risk, focusing on improving the care and quality of specific pathways and new models of integrated care.

Micro-level interventions would be delivered through locality delivery teams - in Leeds the development of the 13 Neighbourhood Teams. This local delivery enables interventions and approaches to be tailored in relation to local need and priorities and also to enable

the accountable care structure to direct resources differentially across the 13 teams to address inequalities.

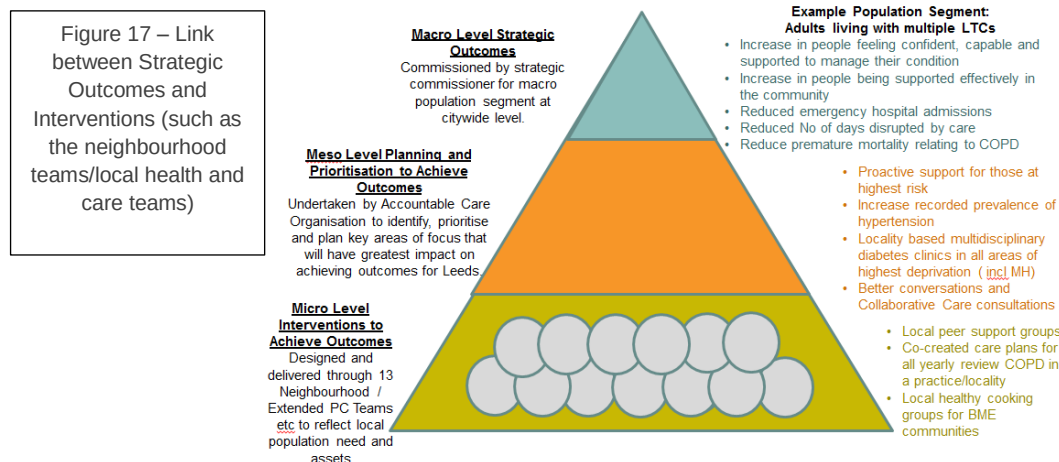


Figure 17 describes how this approach can be delivered, the table below sets out a high-level summary of the key functions, both as they sit currently and as they will be in the future.

This separates the future role of the Strategic Commissioner and System Integration Function based upon the contents of this Blueprint, cognisant of the fact that both functions fall under the Leeds Clinical Commissioning Partnership and also that there are several functions that are currently being incubated by the Strategic Commissioner:

	Current Role	Future Role
System - joint leadership (Commissioner and Providers)	• Shared vision for the city under Leeds Health & Wellbeing Strategy • PEG in situ to oversee the programme • Shared discussions between Directors of Finance • Delivery of workstreams under Leeds Plan and schemes by organisation	• Governance is strengthened system-wide to hold decisions on finance, population segments, outcomes, clinical model etc as set out in Chapter 4 • Set design principles for future redesign of services • Shared view of scale of challenge (£, demographic etc) and system-wide plans / resources to address

	Current Role	Future Role
Strategic Commissioner	• Pathway redesign • Scaling New Models of Care • 'Business as usual' commissioning and quality assurance • Holding "incubated functions" • Define new skills and capabilities that will be required in order to enact this Blueprint.	• Some functions to be undertaken at West Yorkshire footprint or by providers - commissioner may become smaller • More joint commissioning between CCG and Local Authority with stronger focus to support shared decision-making • Enable change at pace - set the direction and create the commissioning and contracting environment for providers to collaborate. This includes removing barriers and identifying activities which can stop in order to focus upon driving PHM • Lead population segmentation and definition of priority segment(s) • Lead development and implementation of outcomes-based contracts by population segments • Contract management and quality assurance

	Current Role	Future Role
System Integration Function	• Develop system relationships • Facilitate provider development to enable a joined-up provider response to the defined population • Facilitate joint accountability • Enable a shift to a population approach to commissioning and provision • Develop a risk and gain share approach across the system • Support leaders to drive system change • Provide specific expertise to support provider maturity to deliver outcomes-based contracts e.g. modelling financial impact, contracting, risk sharing etc. • Draw on resources of Strategic Commissioner to support activities required • Facilitate new models of care pilots and progress Leeds Plan projects to ensure they are supportive of the move to PHM.	• To continue to undertake current tasks, with the function potentially being subsumed into an integrated group of providers in the medium/long-term

	Current Role	Future Role
Integrated Providers	• Development of clinical model (e.g. further development of 13 Integrated Neighbourhood Teams) • Areas of innovation - new models of care pilots, pathway development • Increasing collaboration e.g. primary care & community care, urgent care workstreams	• Integrate to work across the system focussed on a population group rather than a set of services (with support from System Integration) • Work with the Strategic Commissioner to develop outcomes and negotiate contracts for the segments proposed • Development and implementation of clinical models and integrated care pathways to improve outcomes - opportunity to innovate and flex within new commissioning arrangements • Understanding of population need, including risk stratification, and measurement of inputs and process measures • Take on “incubated functions” from the Strategic Commissioner and previous System Integration Functions over time • Continue business as usual services, maintaining quality levels - there is recognition that this provides a capacity challenge for providers - see the risks in Chapter 8.

The section above sets out the likely changes at an organisational level. Subject to agreement to the approach described within this document, organisations will need to work internally, as alliances of providers and together as commissioners and providers to develop their own approach to the work plan. This will include the planning and development of new models of workforce, estates and digital technology as part of the overarching enabling programmes of the Leeds Plan.

7.2 Partners

The system changes proposed in this document represent a radical change in the approach to commissioning and provision of health and care across Leeds. The important role of partner organisations in supporting, enabling and constructively challenging the journey cannot be underestimated. The academic expertise offered by the Leeds Academic Health Partnership (LAHP) will be particularly invaluable in supporting the progression of the initial accelerator segment. Similarly, the Leeds Health and Social Care Academy will, in future, play a key role in developing innovative approaches to care delivery and workforce models. Moving forward, we will continue to share development plans with Healthwatch Leeds and to work with them to identify opportunities to enable local people to have their say.

8 - Roadmap and Project Management

This Blueprint provides a framework and an approach to taking forward actions which will support the delivery of the objectives of the Health and Wellbeing Strategy. It is therefore key that there is a clear route identified for how this work can be taken forward. This will need to be updated on a continual basis, but it is important to consider and agree realistic timeframes from this complex and important set of actions.

8.1 Roadmap and Timeframes

A high-level Roadmap has been provided which builds upon the work undertaken to develop this Blueprint and from the output from the enabling workstreams. The table below sets out key milestone steps of the plan, with a more detailed set of actions provided in Appendix A:

Key activity	Timescales
Sign off Blueprint including system level changes and macro segments	Sept 2017
First accelerator segment selected	Sept 2017
Agree methodology to identify financial envelopes for all segments and produce 'first cut' of budget for initial accelerator segment	Dec 2017
Overarching outcomes framework developed	Mar 2018
Budgets confirmed for all segments	April 2018
Governance and contractual mechanism for outcome based commissioning of segment agreed. Regulatory support acquired.	Jun 2018
Shadow running of first segment & agree second segment	Jun 2018 - Mar 2019
Implementation of 'real' outcomes based contract with payments	Apr 2019 (TBC)
Next segment implemented	Apr 2019 (TBC)

These timescales will be amended and updated as work to implement this programme develops further. Currently, key steps include signing off the Blueprint by PEG and organisation Boards, providing the go ahead for the further steps. These include the next key step which is the selection and signalling to providers of the accelerator segment.

8.2 Risks and Opportunities

Through the work that has been undertaken to develop this Blueprint, a number of risks and opportunities have presented. Moving forward, a formal risk log will be kept in order to capture and mitigate risks as they arise. Workstreams will continue to drive this work forward, maximising the opportunities that have been identified. A summary of these risks and opportunities are provided in the table below:

Risk/Opportunity		Action
Risks	Provider capacity to mobilise and respond to the delivery of outcomes for the initial population segment while simultaneously participating and supporting pathway re-design and responding to procurements not associated with the accelerator population segment.	- Release provider capacity by relaxing specific areas of current contract delivery e.g. use of block contracts - Direct capacity and capability of System Integration (SI) function to undertake and enable providers to establish key facets of PHM - Strategic Commissioner (SC) works in partnership with providers on other areas of redesign (including those within Leeds Plan).
	Joint commissioning arrangements and decision making at a system level continues to be unclear, resulting in a lack of system-wide leadership	- Strengthening the governance recommendations made within the Blueprint - On-going review of the function of ICE - Positive discussions at PEG regarding consolidating and strengthening system level leadership and decision making at a city-wide level
	Current and on-going areas of re-design progressed and led by Strategic Commissioner undermine move towards overall PHM approach and therefore challenge the establishment of a PHM approach for subsequent population segments.	- Strong leadership and connecting of SI and those leading re-design within SC - Agreement that all redesign undertaken within SC supports agreed PHM principles
	Misalignment between provider priorities and initial population segment	- System Level Changes work proposed in this Blueprint to be continued to provide clarity across the system in relation to the system-wide priorities for Leeds - Double running of Approaches 1 and 2 (population based and pathway based) simultaneously will support greater alignment of provider priorities and progress with the segment

Risk/Opportunity		Action
	Resistance from existing Leeds Plan SROs and Programme Plan to change structure and format of Leeds Plan and transfer relevant sub-projects into PHM programme for initial population segment	- On-going discussion and engagement is critical - Progress so far has been positive and constructive but there is more work to do subject to agreement to this Blueprint
	Complex regulatory environment and ISAP may delay the implementation of the initial accelerator segment and prevent the full implementation of the ambition described in the Blueprint.	- Apply lessons learnt and realistic timescales to undertake ISAP process into Roadmap. - Seek specialist expertise in relation to regulatory requirements. - Ensure full and comprehensive engagement undertaken from outset as per Communications and Engagement plan.
	CCGs requirement to go out to tender undermines the collaborative work that is being done across providers	- PEG acting as a voice for Leeds to NHSE, setting out the need for a system approach and that the development of trust and openness is critical to taking forward PHM - Agreement to take calculated risks as a system
	Funding is an issue - particularly for double running	- Remove commissioning activities (such as tendering) that could free-up time to enable double running - Detailed, system-wide modelling of phasing of initiatives
	Some organisations may be defensive and resistant to change as PHM may have an impact on their long-term viability or core contractual income	- System leadership and up-front dialogue regarding the implications of Blueprint - The system alignment work did not find significant reluctance or concern from providers - generally, there was an appetite for change - Work to be undertaken to socialise the Blueprint and its implications with individual organisations

Risk/Opportunity		Action
	Pressures during winter disrupt relationships and as a result, progress towards PHM	- Winter planning is underway - Leaders across Leeds see PHM as a route to alleviating these pressures in future through better care for the population and for making providers jointly accountable for outcomes
	Clinical involvement and leadership is an issue and needs to be clearly described	- This is a key task for the system leadership in taking forward PHM and will form part of the future clinical engagement approach
	Capability of teams across Leeds to achieve and deliver contracts for PHM may be limited	- Learning from other locations is critical, as is staff development. A training programme for Outcome Based Commissioning is already being delivered - Specialists will be brought in where these are required and add value, with a focus on knowledge transfer and joint working
Opportunity	Strong relationships across Leeds exist, and the existence and function of PEG provides a platform for the leadership of PHM	- PEG endorse the Blueprint document and its recommendations through setting up a System Leadership Group with the ability to make delegated decisions
	The existence of a System Integration function provides a ready-made team to drive this work forward with providers and the Strategic Commissioner.	- Clarity around roles and responsibilities, especially with the Strategic Commissioner, is vital - Providers must demonstrate willingness to work with the System Integration function in order to maximise the benefit of this “catalyst” function
	Providers have indicated their wish to make rapid progress with PHM and have shown pro-activity already in the development of service and contracting models	- This positivity and progress must be matched and built upon by the system and commissioners. The development of the System Changes enables this progress to shaped in-line with the system aims for Leeds

Risk/Opportunity		Action
	Leeds is a national leading site for linked data	- This opportunity must be maximised, using its availability to drive rapid progress where other systems across England have stalled. Continued engagement with experts in the data team is critical
	New models of care test beds are positive and potentially provide a platform for further development - solving issues in advance of PHM (for example issues with clinical indemnity)	- Shaping these initiatives and ensuring they are supportive of the move to PHM means that this progress is directly supportive of future work - Learning from these initiatives across Leeds is vital to include as work progresses

Subject to the agreement to progressing this Blueprint, these risks and opportunities will be taken forward by workstreams in order to mitigate any impact and to maximise the opportunities that these present.

8.3 Summary of Next Steps

This section has described the plan for how PHM can be taken forward across Leeds. Critical next steps include discussing this document with leaders across Leeds and gaining sign-off from both PEG and organisations' Boards. It is anticipated that a final version of this Blueprint can be taken to PEG in September for sign-off.

This work can then be rapidly progressed, based upon the good work already happening across Leeds and the segmentation, outcomes, data and finance and contracting workstreams.

In the short-term, agreement will be needed across organisations to commit staff time and resources to the delivery of the Blueprint. This will include minimum participation in meetings and a clear understanding of the resource commitment from organisations to each of the tasks. This may need to be captured in a memorandum of understanding (MoU) or similar document which can be signed-off.

The Blueprint and Roadmap will require continued updating over the summer and in association with this, the following key actions are critical:

- Strengthen the governance structures for making system level decisions across Leeds
- Develop and implement an approach to benefits realisation for PHM
- Clarify resource commitment from each organisation to take work forward
- Agree the System Level Changes needed to deliver the Leeds aims
- Design approaches to leadership and organisational development and a plan for engagement with key stakeholders including citizens
- Undertake financial modelling across population segments

- Within the context of the current regulatory environment, continue discussions with finance leaders regarding new types of contracts and financial risk
- Agree the approach to segmentation, the method for selecting an accelerator segment, and agree what this segment will be
- Develop outcome measures for this segment following the approach outlined in this document.

It is clear that we must move away from working under great pressure to address the symptoms of a fragmented system and move towards investing time and effort in fixing the system - delivering integrated, accountable service focussed upon the delivery of outcomes and not measuring inputs and processes. This will be a long term transformation. Providers are already progressing new service models and there are pockets of good practice across the city. The key is to act and to lead as a whole health and care system, harnessing this impetus and commitment to free providers from current contractual structures so that they can truly innovate and integrate care around populations of need.

In conclusion, it is clear that the city is keen to make progress at times providers feel there is a risk that they could feel held back by commissioners at present. It is also clear that were the system to select a population segment with providers and that that it wished to contract for this differently in a period of time, that this would provide momentum for the work described in this document. This is seen as a key opportunity and next step and one that should be taken soon in order to build upon the good work already happening across providers demonstrate and put in to practice the role of the strategic commissioner and system integration function, test out emerging provider alliances, and to show commitment to PHM at a system level.

9 - Glossary

Accelerator Segment	Accelerator Segment is the local term used to describe the first population group that Leeds will identify and implement a Population Health Management approach with.
Accountable Care	Accountable Care describes arrangements where a group of providers are collectively responsible for the delivery of care for a population. In this situation, providers are responsible to each other for the cost and quality of care delivered to a population of people.
Accountable Care Organisation/ System / Partnership (ACO /ACS/ ACP)	An Accountable Care Organisation, System or Partnership can be defined as a group of health and care providers – which may include primary, community, acute and social care – who work together and accept collective responsibility for the cost and quality of care delivered to a population of people. The structure and way in which Accountable Care is organised and delivered between providers varies in form and scale between Accountable Care Organisations, Accountable Care Partnerships and Accountable Care Systems. Latterly, the term Accountable Care Systems has been used to refer to Accountable Care arrangements between providers at regional scale on STP footprints or comparable areas. https://www.kingsfund.org.uk/publications/accountable-care-organisations-explained
Better Conversations	Better Conversations describes a key principle in Leeds that quality conversations with people make a difference to people's experience and outcomes. This is especially the case when used positively by health and care services to work with people to find solutions with people as opposed to identifying solutions for people.
Integrated Support and Assurance Process (ISAP)	The Integrated Support and Assurance Process (ISAP) is a national, 'gateway' assurance process for the review and assurance of procurement and transactions related to complex contracts. It enables all parties to learn from previous successes and failures and implement best practice. <i>See references for more information</i> https://www.england.nhs.uk/wp-content/uploads/2017/08/integrated-support-assurance-process-part-b.pdf

Leeds Health and Care Plan (Leeds Plan)	The Leeds Health and Care Plan is a description of what health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is the city's place-based plan to support the West Yorkshire & Harrogate Health and Care Partnership (previously known as the 'STP'). The Plan describes how the city can close key gaps in health and care outcomes, health and care quality and the financial sustainability of services. This is enabled through a move towards a community focused approach, which understands that good health is a function of wider factors such as housing, employment, environment, family and community. <i>See references below for more information</i> http://democracy.leeds.gov.uk/mgConvert2PDF.aspx?ID=163298
Leeds Health & Wellbeing Strategy 2016-2021	The Leeds Health and Wellbeing Strategy is about how we put in place the best conditions in Leeds for people to live fulfilling lives - a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people and this is the strategy for how we will achieve that. It is led by the partners on the <u>Leeds Health and Wellbeing Board</u> and it belongs to everyone in the city. <i>See references below for more information</i> http://www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf
Multi-specialty Community Provider (MCP)	An MCP is one of a number of 'New Model of Care' described in the NHS Five Year Forward View. It describes a new integrated provider made up from multiple individual providers including Primary and Community Care. Nationally, 14 MCP 'Vanguards' have been established to test, learn and understand the benefits of this new form of provision and associated contract. <i>See references below for more information</i> https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/community-sites/

Integrated Neighbourhood Teams	The Health and Social Care Integration Programme has led to the development of 13 Integrated Neighbourhood Teams across Leeds. The current aim of the teams, which consist of adult community health services, adult social care and aligned General Practices, is to improve and coordinate care and support around the needs of older people and those with long term conditions. In Leeds, Neighbourhood Teams are likely to form the basis of the future delivery model for the initial and subsequent population segments. Teams will work together around clusters of GP Practices to provide proactive input to prevent ill health and deterioration of health. Adopting learning from the national Primary Care Home model and reflecting new national requirements to establish extended Primary Care Teams and Primary Care Networks, the final name and geography of the 13 teams has yet to be confirmed. <i>See references below for more information</i> https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/neighbourhood-teams/neighbourhood-teams/
New Models of Care (NMoC)	New Models of Care (NMoC) were first described in the NHS Five Year Forward View. They represented new forms of more integrated service provision to deliver better quality outcomes for patients. They included Multispecialty Community Providers (MCP), Primary and Acute Care Systems (PACS), and Care Homes Framework. Nationally, 'Vanguard' sites have been selected to test and generate learning in relation to these NMoC. Locally, the term NMoC has also been used within the Leeds CCGs to describe pilot projects where Primary, Community, Acute and Third Sector providers have worked together to develop and test integrated care that responds to local population needs. <i>See references below for more information</i> https://www.england.nhs.uk/ourwork/new-care-models/

NHS England (NHSE)	NHS England commissions <u>specialised services</u>, <u>primary care</u>, some public health services, <u>offender healthcare</u> and some services for the armed forces. It has four <u>regional teams</u> but is one single organisation operating to a common model with one board. <i>See references below for more information</i> https://www.england.nhs.uk/commissioning/
NHS Improvement (NHSI)	NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They offer the support to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, they help the NHS to meet its short-term challenges and secure its future. <i>See references below for more information</i> https://improvement.nhs.uk/about-us/who-we-are/
One Voice	‘One Voice’ is the local Organisational Development programme established across the Leeds CCGs in September 2016. The One Voice programme has driven the integration of commissioning functions across the Leeds CCGs to support more Strategic Commissioning and the formation of the System Integration function to enable provider integration as part of a wider move towards a Population Health Management approach.
Leeds Health and Care Partnership Executive Group (PEG)	The PEG (also known as the Leeds Health and Care Partnership Executive Group) is the forum of the leaders of the Leeds’ health and care commissioners and providers. Its membership includes leaders from the Leeds CCG Partnership, Leeds Teaching Hospital Trust, Leeds Community Healthcare, Leeds and York Partnership Trust, General Practice, Adult Social Care, Public Health, Leeds City Council and the Third Sector. The forum does not have formal decision making powers and decision making is made through the delegated authority of its membership.

Place-based Care	Place based care describes the delivery of care, by a group of health and care providers who collaborate to address the challenges and improve the health of the populations they serve. The focus is on the needs of the population as opposed to needs of individual provider organisations. <i>See references below for more information</i> https://www.kingsfund.org.uk/publications/place-based-systems-care
Population Health Management (PHM)	The definition for Population Health Management (PHM) adopted by Leeds recognises that health and wellbeing is more than just being ‘without disease. It moves away from managing disease in silos to an approach based on defined populations of people, who may have multiple ‘disease conditions’ or life challenges. It provides a framework for the whole population across all age groups. In Leeds, PHM is described as: - Improving population outcomes through a whole system approach where commissioners and providers work together to define, measure and improve population outcomes. - Designing, organising and integrating the full cycle of care around the needs of a population group by moving away from organisational silos towards jointly accountable care. - Supported by a strategic approach to commissioning which measures and values delivery of key outcomes for defined population segments, rather than the traditional emphasis on processes, pathways and activities. - Fully utilising data and informatics solutions to direct care interventions to where they are most needed, and better support professionals in joint working.
Primary Care Home	Primary Care Home is an innovative approach to strengthening and redesigning primary care. Developed by the National Association of Primary Care, the model brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community. <i>See references below for more information</i> http://www.napc.co.uk/primary-care-home
Segmentation	Segmentation refers to the grouping of populations according to similar characteristics.

Strategic Commissioning	Strategic commissioning encompasses the funding and planning of services in addition to holding providers to account for the delivery of agreed outcomes. Strategic commissioning is quite different to how commissioning is currently understood and practised in the NHS. In Strategic commissioning many of the functions currently undertaken by NHS commissioners become the responsibility of providers eg needs analysis, engagement, service planning, measurement and evaluation.
System Alignment	System Alignment was a process undertaken as part of the development of the Blueprint. It involved interviews with over 30 leaders across health and care in Leeds to understand individual's vision for the future, their understanding and articulation of where Leeds is now, and their view for how the work can be taken forward
System Integration Function	System Integration is the term used to describe the function which brings together commissioners and providers within a defined health and care system to achieve local aims and ambitions.
System Relationships	This is a local term used to describe the relationships between leaders of health and care organisations across Leeds to ensure good working relationships for the whole system to work efficiently.
Test-beds	This is a local term used to describe areas in Leeds that are piloting or testing areas of innovation including locally developed New Models of Care.
<u>West Yorkshire Association of Acute Trusts (WYAAT)</u>	The West Yorkshire Association of Acute Trusts (WYAAT) is an innovative collaborative which brings together NHS trusts delivering acute hospital services from across West Yorkshire and Harrogate to drive forward the best possible care for our patients. <i>See references below for more information</i> http://democracy.leeds.gov.uk/documents/s140126/2%20WYAAT%20-%20Appendix%201%20-%20WYATT%20Summary.pdf

West Yorkshire & Harrogate Sustainability and Transformation Plan (WYH STP)	The West Yorkshire & Harrogate Sustainability and Transformation Plan (WYH STP) is an opportunity for all of the services that work across health and care in Leeds to agree a shared plan for the next five years. Leeds is contributing to a joint West Yorkshire & Harrogate STP, which alongside plans from other areas of the country, has been requested by NHS England but we are also developing our own citywide plan to complement this. <i>See references below for more information</i> http://www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/

APPENDIX A

BLUE PRINT FOR POPULATION HEALTH MANAGEMENT
ROADMAP

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Lead Organisation	Timeframe													
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Beyond
Development of the Blueprint and enabling activities	Further development of Blueprint content													
	Identify and apply key learning and approaches adopted by other health and care communities.													
	System alignment and Blueprint key messages discussion at PEG													
	PEG sign-off Blueprint													
	Organisational sign off of the Blueprint													
Establish PHM delivery programme	Develop detailed programme plan (ensure ISAP timescales fully incorporated).													
	Develop detailed Communications and Engagement Plan (including compelling public facing narrative)													
	Develop and agree programme structure Inc. PMO, Risk management, Governance, internal and external reporting arrangements													
	Confirm leads and organisational resourcing (people) to deliver programme.													
	Deliver and position PHM Programme plan, structure and expectations within key fora (Inc. CCG SMT, PHM, Accountable Care Development Board, ICE).													
Workstream 1 Rapid Progress with PHM (Accelerator Segment)	Scope and confirm level of ambition for segmentation													
	Undertake wider engagement to test and agree macro framework, prioritisation methodology and identify accelerator segment (including clinical input)													
	Confirm governance to sign-off approach and recommended accelerator segment													
	Data analysis to support prioritisation of a population segment:													
	Segment analysis - identifying how the population falls into each segment													
	Selection of first population segment (the Accelerator Segment)													
	Recommendation re initial accelerator segment to PEG													
	Undertake initial skills development in commissioning for outcomes for existing commissioning teams													
	Set up Accelerator Segment Group													
	Develop plan for staged approach towards <u>all</u> population segments reflecting regulatory environment and lessons learned from other areas.													
	Develop methodology to agree financial envelopes for segments and produce first cut of budget for initial accelerator segment													
	Undertake modelling of financial envelopes for all segments.													
	Signal likely phasing of the future segment to be commissioned													
SI														
SI														
BDO														
PEG														
Individual organisations														
SI														
SI & SC														
SI & HPT														
PHM														
PHM														
SI/PHM														
Segmentation workstream														
PEG														
Public Health														
PHM														
PHM and extended workshop														
PEG														
SC														
PHM														
PHM														
PHM														
PHM														
PHM														
PHM														

	Develop overarching outcomes framework for all segments as a signal to providers	PHM													
	Clarify and develop metrics, including how to measure person-centred outcomes, and information governance arrangements	PHM													
	Develop governance and contractual management processes for the outcome based commissioning of the segment - incorporate all ISAP requirements	SC													
	Providers analyse the need and the risk of the population segment that has been selected - and opportunities make impact to improve care	ACDB													
	Providers scope and identify meso and micro level actions and interventions relating to initial population accelerator segment	ACDB													
	Contractual discussions and agreement	SC & Providers													
	Operate in shadow form	SC & Providers													
	Shadow form completes and moves into real outcome payment	SC & Providers													
	Share learning from Accelerator segment	PHM													
	Planning for future work across additional segments														
	Reconfirm second segment	PHM													
	Follow Accelerator approach for the second segment	PHM													
	Provider development														
	Providers work together to create service models, meso and micro segmentation (at a geographical/risk level) and more detailed outcome/input/process measures	ACDB													

Evolution of the Leeds Plan	Reviewing on-going work to ensure consistency with PHM - work with all work streams to identify work areas that support initial segment.	PHM & LPDG													
	Link system change logic models to the Leeds Plan	PEG & LPDG													
	Ensure Leeds Plan narrative and Communications and Engagement Plans align with PHM plan.	LPDG & PHM													
	Evaluate where to scale up and roll-out "test beds"	SC													
	Amending the management and governance of the Leeds Plan - new timescales, financial plans and governance.	LPDG													

SI = System Integration; SC = Strategic Commissioner; HP = Health Partnerships Team; PEG = Leeds Health and Care Partnership Executive Group; ACDB = Accountable Care Development Board

Leeds Health and Wellbeing Board



Report author(s): Susan Robins

Report of: Susan Robins (Director of Commissioning, NHS Leeds CCGs)

Report to: Leeds Health and Wellbeing Board

Date: 28 September 2017

Subject: Leeds Health and Care Local System Delivery Plan 2017-18

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ 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

The Leeds Health and Care Local System Delivery Plan 2017-18 is an operational plan that is supported by a narrative document (Appendix 1). It describes the preparation and work undertaken by the Leeds health and social care system during 2017 to prepare for surges in demand, most frequently seen during winter.

It plays an important role in contributing to the delivery of the vision and objectives of the Leeds Health and Wellbeing Strategy 2016-2021. A resilient system is one that is able to maintain service delivery and high quality care to patients even during times of pressure and high demand.

The plan also supports the Leeds Health and Care Plan in its ambitions to make progress against addressing the three gaps that have been identified by health, care and civic leaders. These are gaps in: health inequalities; quality of services; and, financial sustainability.

Recommendations

The Health and Wellbeing Board is asked to:

- Agree that the approach taken to plan for winter aligns with our shared city ambitions
- Reinforce our shared ownership and collective action as 'Team Leeds' as we deliver Leeds Health and Care Local System Delivery Plan 2017-18

1 Purpose of this report

- 1.1 The purpose of this report is to provide the Health and Wellbeing Board with a brief overview of the Leeds Health and Care Local System Delivery Plan 2017-18 and to give further details in the narrative document attached. The report and appendix also includes information about key workstreams and next steps to progress the delivery of the Plan, as well as what will be different in 2017/18. This item also responds to feedback from the Health and Wellbeing Board workshop on 20 July 2017.

2 Background Information

- 2.1 Variation in the demands across a health and care system is normal and occurs throughout the year, but last winter was really challenging for health and care services. Although we did not experience any adverse weather or significant outbreaks over winter, we saw the highest system challenge and poorest patient experience and performance across our system. The stress both on services and individuals was apparent and relationships across organisations were highly tested.
- 2.2 Due to an increasing national focus on the resilience of local health and care systems, 2017/18 saw formal winter planning starting in July for the first time. The Leeds System Delivery Plan responds to NHS England / NHS Improvement's requirement for Local A+E Delivery Boards(the Systems Resilience Assurance Board (SRAB) in Leeds) to undertake more in-depth resilience planning for 2017/18.
- 2.3 Final plans will be submitted in a standard, technical template to NHS England/NHS Improvement in early September. A draft narrative has been developed to accompany the technical document, which is attached with this report. This outlines how Leeds plans to be equipped, prepared and coordinated to respond quickly and appropriately in a systematic and co-ordinated way to manage any change in demand or circumstances.

3 Main issues

- 3.1 The foundation of the Leeds Health and Care Local System Delivery Plan 2017-18 is to deliver person centred safe & effective care through partnership working, building on lessons learned from 2016/17. It is a 36 point operational working document shared by the system that details all the current workstreams. This is supported by a narrative document that is included with this report for consideration by the Leeds Health and Wellbeing Board.
- 3.2 The plan directly contributes to the shared ambitions of the Leeds Health and Wellbeing Strategy 2016-2021, its vision and its objectives, to set out a series of actions that will make our services more resilient in order to achieve its aims.
- 3.3 The plan recognises and references the collaborative work done by partners across the region to through the West Yorkshire and Harrogate Health and Care Partnership (previously STP). Through the Urgent Care workstream, Leeds is linked into that work at regional level, sharing learning and seeking innovative solutions to issues from partner organisations.

- 3.4 An important element in informing the planning process for the Leeds Health and Care Local System Delivery Plan 2017-18 was the early evaluation of winter 2016/17. Increased acuity saw high numbers of sick people admitted through non elective pathways resulting in prolonged delays in hospital for people requiring ongoing care. This placed additional pressures on our workforce in terms of capacity and case mix across all points of delivery. As a result the system became compromised and consequently we saw services become compacted.
- 3.5 It was evident that if we are to have further impact in 2017/18 we needed a more proactive approach with early planning and strong system leadership and commitment. Planning started in March 2017 with system agreement on the priority areas building a vision of what would be different in 2017/18 articulated through the Leeds Health and Care Local System Delivery Plan 2017-18.
- 3.6 The Leeds Health and Care Local System Delivery Plan 2017-18 narrative document contains information about:
- The National NHS 9 point plan- the mandated elements of system delivery that must be delivered, such as GP streaming in A&E , or work to support care homes manage patients with urgent needs, or how we work with NHS 111 system and increasing clinical assessment at the point patients phone 111
 - What worked well during winter 2016/17 and what did not work so well- the learning we gained from last winter
 - The risks and mitigation
 - The Governance of the plan and how delivery of it will be monitored
 - The refined escalation for Leeds- improvements that have been made and how it will work to greater effect in future

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 As progress is made on the workstreams within the Leeds Health and Care Local System Delivery Plan 2017-18, engagement and/or consultation will be in line with existing guidance and best practice.
- 4.1.2 Rooted in the Leeds Health and Wellbeing Strategy, the Health and Wellbeing Board has committed to Leeds needing a renewed conversation with Leeds citizens about their health, wellbeing and care. This is reflected in many of the city's shared strategies and approaches, including the Leeds Health and Care Plan. Building on previous experience and evidence, Leeds will need to agree the conversations with the public regarding the optimal use of services. Aligned with this work, a detailed communication and engagement plan for patients, the public, and health and social care staff is currently being developed and this will be assessed by the NHS Leeds CCGs PAG (Patient Assurance Group) before being agreed by SRAB (System Resilience Assurance Board).

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Any future changes in service provision arising from the plan will be subject to equality impact assessment.

4.3 Resources and value for money

- 4.3.1 All elements of the plan have been assessed for financial impact and funding sought to commence or maintain projects as appropriate.

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 A separate risk register has been developed to support the plan's delivery with both impact and variable risks identified. These include workforce risks, unprecedented demand, variables such as adverse weather or a flu outbreak. All risks have been assessed and mitigated as appropriate.
- 4.5.2 Failure to have robust plans in place to address the gaps identified as part of the system delivery plan will impact the sustainability of the health and care in the city.
- 4.5.3 Each provider organisation has robust and tested business continuity plans and major incident plans which are regularly tested.
- 4.5.4 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city.

5 Conclusions

- 5.1 The foundation of the Leeds Health and Care Local System Delivery Plan 2017-18 is to deliver person centred safe & effective care through partnership. All organisations within the Leeds Health and social care system have come together much earlier during 2017 in developing a jointly owned plan that aims to maintain services and uphold the required standards of patient safety and quality.
- 5.2 We have taken learning from the winter of 2016/17 and reviewed many service areas to seek improvements and robustness.
- 5.3 We have developed several new services to support system resilience. The narrative attached details what will be different to services for our workforce and citizens.
- 5.4 National learning and mandated service developments such as described within the NHS 9 point plan, have been incorporated into the Leeds Health and Care Local System Delivery Plan 2017-18

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Agree that the approach taken to plan for winter aligns with our shared city ambitions
- Reinforce our shared ownership and collective action as 'Team Leeds' as we deliver Leeds Health and Care Local System Delivery Plan 2017-18.

7 Background documents

None



How does this help reduce health inequalities in Leeds?

The Leeds Health and Care Local System Delivery Plan 2017-18 being system wide and covering the full range of services from primary care through acute care and back to community services covers the full range of presenting condition and population groups. We know that ill health is linked to health inequalities and so this plan seeks to support all patients to get the assistance they need in a timely way in a place and service most suited to their particular needs.

How does this help create a high quality health and care system?

See above

How does this help to have a financially sustainable health and care system?

See above

Future challenges or opportunities

The communications plan for the Leeds Health and Care Local System Delivery Plan 2017-18 enables us to commence different conversations with the public in Leeds regarding how best to use services during a time of urgent need.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21

A Child Friendly City and the best start in life	
An Age Friendly City where people age well	
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds Health and Care Local System Delivery Plan 2017- 18

Version Control

Date	Version	Status
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Storage – Electronic	Sarah Exley, CCG Urgent Care team

Executive Summary

The foundation of the Leeds system delivery plan is to deliver person centred safe & effective care through partnership working, building on lessons learned from 2016/17.

In 2016 /17 'winter' had a marked impact on our services and the experience of care for our population. Our performance against national standards dropped and we saw a disruptive effect on flow across all points of delivery in our system. A more proactive approach to our plan for 2017/18 was therefore required.

Our planning process this year is aligned to the NHS 9 Point Plan for action on A&E incorporating a 'lessons' learned to consolidate the initiatives that worked well last year across the country.

We will make improvements on areas where things did not work so well and be ambitious in initiating new areas of development where we believe we can achieve efficiencies and demonstrate impact across our system for the benefit of patients.

Building on the partnership working in Leeds we continue to take a whole system collaborative approach to the planning and delivery of our services that is transparent, timely and transformational.

All partner organisations in Leeds must be clear that the success of the plan is dependent on commitment to collaborative working across organisational boundaries. We will collectively focus on new ways of working across localities, communities and acute settings to ensure people receive the care/response they need in the right setting first time.

To support our system status the new Operational Pressures Escalation Levels processes will permit a proactive system management approach that is built on mutual aid principles.

The plan's effectiveness will be assessed by the flow of patients between services. This is crucial at times of surge in demand. Smooth patient flow is the key test of any system during peaks in demand. We have comprehensive data for monitoring in place.

Evaluation will be continuous. A dashboard will be developed to highlight this plan's impact. By consistently assessing the impact, we will adjust delivery across our system ensuring sustainability and a timely recovery during times of significant pressure.

The associated Leeds system delivery plan (operational plan) and this narrative document will be referred to as the LSDP

1. National and regional context

Variation in the demands across a health and care system is normal and occurs throughout the year. Leeds Health and Care economy needs to be equipped, prepared and coordinated to respond quickly and appropriately in a systematic and co-ordinated way to manage any change in demand or circumstances.

There is an increasing national focus on the resilience of local health and care systems. NHS England and NHS Improvement continue to emphasise the importance of improving the delivery of urgent and emergency care pathways through a national programme of 'Action on A&E' workshops to ensure systems work together sharing good practice in an innovative and collaborative way.

Nine National work streams have been agreed to support developments, monitor progress and achieve national consistency. The nine work streams are:

- A&E streaming
- Patient Flow
- Community capacity
- Mental Health
- NHS 111 service developments
- Primary Care including GP access
- Care Homes
- Urgent Treatment Centres
- Ambulance response programme

In addition to the nine national work streams the Leeds LSDP has three additional work streams to build a comprehensive and inclusive system plan these are:

- Public Health
- Communication
- System management, Escalation and Mutual Aid

Local health and care economies are required to develop a Local System Delivery Plan (LSDP) built around these nine priorities to support the delivery of the 4 hour Emergency Care Standard (ECS) and sustain their ability to flow people through services in a timely way preventing delays in meeting patient's needs.

The Better Care Fund (BCF) guidance also places significant focus on the development of out of hospital services with a specific aim to improve system flow to reduce non-elective admissions and Delayed Transfers of Care (DToC).

2. Strategic objectives and system indicators

Aligned to the National 9 point Action on A&E plan and the national Operational Pressures Escalation Levels (OPEL) the LSDP aims to provide continuity in safe, high quality services for people.

The objective of the plan is that the Leeds system delivers smooth and timely patient flow and remains functioning and resilient during time of demand surge and high pressure.

The strategic system indicators (key metrics) of the plan are:

1. No patients in non-designated beds within Leeds teaching Hospital Trust
2. Achievement of 95% ECS 4 hour A&E target
3. Reduction in the number of non-elective admissions
4. No cancellation of elective surgery within 48 hours
5. Reduction in the number of lost bed days associated with Delayed Transfer of Care (DToC)
6. Reduction in the number of people experiencing delays for community nursing support
7. Reduction in the number of people admitted into long term care
8. Management of clinical risk across the system
9. System status no higher than OPEL level 2

The outcomes will be achieved by a range of initiatives at both local Leeds system and regional levels that will both improve services and the processes that underpin delivery. The work streams and initiatives set out:

- Executive and operational responsible leads
- Clear aims and objectives
- Key milestones with timescales
- Impact assumptions and system benefits
- Funding and contracting considerations
- Key risks
- Key performance indicators and the contribution to the system indicators

The plan will be monitored by the Operational Resilience Group reporting to the Leeds System Resilience Assurance Board.

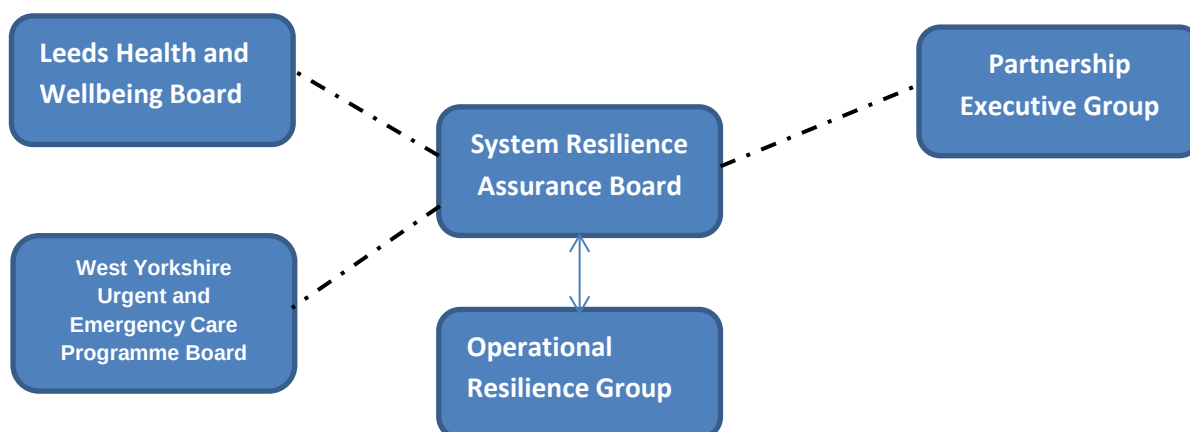
3. Governance

A resilient health and care system is equally reliant on all partner organisations being able to deliver their care elements safely. Each organisation has individual business continuity and major incident plans monitored through their own Boards and through contracts.

The governance of the essential cross organisational communication and collaboration is harder to define, with several groups having a role such as the Integrated Commissioning Executive, the Partnership Executive Group, the SRAB and the Health and Wellbeing Board.

The LSDP is a partnership plan, to be owned by all partners, with executive commitment co-ordinated by the CCG's. The overarching principle of the plan is 'that the outcomes will only be achieved through a collaborative approach to the inputs' therefore responsibility and accountability for the delivery of LSDP lies with all participating organisations.

3.1 Leeds System Delivery Plan - Governance structure



3.1.1 Health and Wellbeing Board and the Partnership Executive Group

As a system plan the LSDP will be shared across all partnership forums to provide information and assurance. The plan will also be shared with the public. Both the Health and Wellbeing Board (HWB) and the Partnership Executive Group (PEG) have been involved in the development of the plan.

3.1.2 System Resilience Assurance Board

An executive level multi-agency system group, the System Assurance Resilience Board (SRAB) has responsibility for assuring the coordination and delivery of a sustainable system to maintain all health and care services including delivery of the Emergency Care Standard. (4 hour A&E target) A dashboard will be developed that will be performance managed by the SRAB. The SRAB will also maintain oversight of the plan and drive improvement in performance and delivery.

3.1.3 Operational Resilience Group

An operational multi-agency system group, the Operational Resilience Group (ORG) was established in 2016 and has responsibility to deliver mandated actions from SRAB. The ORG is responsible for the implementation, monitoring, escalation and evaluation of the LSDP as well as the daily management of the system.

3.1.4 Regional West Yorkshire Urgent and Emergency Care Programme Board - Sustainability and Transformation Plan

The West Yorkshire Sustainability and Transformation Plan (STP) have established an Urgent and Emergency Care Programme Board to co-ordinate and monitor the progress of the individual health and care system across West Yorkshire. It provides a forum for understanding, discussing and highlighting both local and regional services and issues that have an impact on associated economies, e.g. ambulance and trauma services. We will remain part of this network and seek opportunities at WY level to improve services in Leeds.

4. Local Leeds context

4.1 Winter 2016/17 evaluation

An important element in informing the planning process for the LSDP for 2017/18 was the early evaluation of winter 2016/7 conducted by the ORG and SRAB.

Though we did not experience any adverse weather or significant outbreaks, last winter saw the highest system challenge and poorest patient experience and performance across our system. The stress both on services and individuals was apparent and relationships across organisations were highly tested.

Increased acuity saw high numbers of sick people admitted through non elective pathways resulting in prolonged delays in hospital for people requiring ongoing care. This placed additional pressures on our workforce in terms of capacity and case mix across all points of delivery. As a result the system became compromised and consequently we saw services become compacted. As a result we saw the following impacts on patients and services:

- Patients on trolleys/ beds in non-designated bed areas
- High numbers of people in outlying wards (not always in their appropriate speciality)
- High numbers of delayed transfers of care and medically optimised for discharge patients
- Delayed discharges in community beds comprising community capacity
- High demand for nursing and residential care
- High demand for community services, district nursing, packages of care, equipment, and reablement services.
- Limited Critical Capacity across the system
- High level of Repatriations to other Trusts outside Leeds post specialist care
- Cancelled electives including urgent and cancer surgery
- Additional risk across the system compromising quality and patient safety
- Increased pressure on workforce - impact on staff /service resilience
- System declaring OPEL 3 status for an extended period.
- Sustained non achievement of national performance targets
- High demand on Primary care services
- Higher attendances at Walk in centres
- Higher demand for GP out of hours services

Our evaluation of winter 2016/17 was a valuable exercise. It highlighted what worked well and identified areas for improvement. This enabled us to explore new opportunities, improve and develop services to maximise resources and scope options for mutual aid through the proposed initiatives within the LSDP.

4.2 What worked well in 2016/17

The system historically prepares for the predictable challenges of winter but over the last three years in Leeds we have seen increased system pressure throughout the year. This has highlighted the importance of a collaborative year round planning approach with strong system leadership to address the ongoing challenges that was seen in 2016/17

Successes of 2016/17 to build on:

- Co-ordinated detailed A&E plan to promote a collaborative approach
- Primary Care Stream in A&E pilot to realign resources in the Emergency Department
- Admission avoidance through adult assessment and ambulatory care pathway developments
- Additional bed capacity within LTHT to address surges in capacity
- Leeds & York Partnership Foundation Trust (LYPFT) Rapid improvement events led to reduction in Out of Area Treatments
- Leeds Integrated Discharge Service (LIDS) across discharge wards in LTHT to support improved discharge and outflow
- Transfer of care group – Dedicated to discharge developments
- Short term ring-fenced investment – support additional services during surges in demand
- Mental Health Investment –Liaison psychiatry 24/7 in the ED, community services providing alternative places of safety e.g. crisis café
- Mutual aid – sharing workforce limited but positive impact
- 7 day community respiratory service to support admission avoidance and discharge
- Development of escalation processes -OPEL to support consistent approach and align to national requirements
- National communications campaign supported by Local communications to the people of Leeds

4.3 What did we not do so well in 2016/17

The key highlights from the evaluation for improvement are:

- Communicate systematically and consistently- we didn't always talk the same language about escalation and rising demand and pressures
- Plan ahead sufficiently
- Anticipate cross organisational impact early enough to respond appropriately/effectively – provide system wide support to each other
- 'Mutual aid' / system thinking
- Quantify community bed provision and services
- EMI (complex) bed capacity

- Trusted assessor roles
- Transfer / discharge to assess in a more appropriate setting
- Assess impact on, and contribution of, primary care to system pressures

4.4 What will be different in 2017/18

It was evident that if we were to have further impact in 2017/18 we needed a more proactive approach with early planning and strong system leadership and commitment. Planning started in March 2017 with system agreement on the priority areas building a vision of what would be different in 2017/18.

- **Long term condition management** - Respiratory 7 day service embedded throughout the pathway
- **Community capacity** – Neighbourhood team/practice nurse development, increased capacity within reablement, and equipment, action on care homes support and development, streamlined system referral processes, Progress to reconfigure the Minor Injuries Units (MIU) to meet national Urgent Treatment Centre standards plus additional primary care developments/ extended access to primary care.
- **Community Bed procurement** - Will deliver an additional 49 beds for both intermediate care and transfer to assess capacity. There will also be additional short term community bed capacity commissioned for the winter period.
- **Acute front door** – sustainable integrated primary care streaming service in A&E, multi-agency frailty unit with a strength based approach to need has been piloted to inform implementation options, expanded ambulatory care pathways, MH liaison and third sector involvement regarding frequent attenders.
- **Discharge** - Leeds Integrated Discharge service multi-agency discharge approach , Hospital social work realignment and trusted assessor to provide timely assessments and decision to transfer/discharge, transfer to assess bed capacity.
- **Ambulance Response Programme** – Continued revised coding of ambulance dispatch to support a more appropriate response, Urgent Care Practitioner development in Leeds to 'see / hear and treat' reducing conveyance to A&E
- **System Management, escalation & mutual aid** - Agreed system wide escalation policy with consistent communication, agreement of support offered and what can be stopped at times of escalation
- Ongoing work on **demand and capacity** in all areas of the system, particularly for weekend and BH peaks
- Take learning from the LTHT '**perfect week**' exercise due to run in early October 2017

Delivering a comprehensive plan requires effective co-ordination, communication that promotes system commitment, accountability and transparency. This will be achieved through a detailed operational work plan (Appendix 1) setting out initiatives under the twelve agreed Leeds work streams with clear key performance indicators and risk to delivery identified.

Section 5 provides more detail around a number of the key areas of development within the 12 work streams:

5.1 A&E streaming

LTHT piloted A&E streaming in 2016 / 17 which was positively evaluated and informed new service developments. We have been working with an alliance of providers to deliver a more sustainable and integrated service from October 2017. Patients presenting at the Emergency Department (ED) will be triaged by a clinician and streamed into the most appropriate service allowing the ED resource to be focussed on patients with more acute needs.

5.2 Patient Flow

We have learned that smooth patient journeys are critical for a positive patient experience and effective service delivery. The LSDP is reflective of the importance of effective flow and the impact it has on the system and our population at all points of delivery. The Leeds Integrated Discharge Service (LIDS) and the realignment of hospital social work teams are two areas of focus which will see patients assessed and discharged in a more timely way.

We are progressing options to ensure the sustainability of the LIDS service and expand the service to increase trusted assessors capacity to maximise the opportunities offered by other out of hospital services i.e. equipment.

5.3 Community capacity

There is a national focus on services that maintain people in their own homes and promote self-care and independence. The Hospital to Home element of the LIDS service, delivered by Age UK, supports patients to be discharged home directly from the emergency department or an assessment ward thus avoiding an admission.

Leeds City Council's new reablement service has been a major development in the city in 2017. We are already seeing the benefits of this service that supports patients being transferred out of hospital to receive support to recover. The availability of equipment 7 days a week is a key enabler for reablement and we are also benefitting from the processes developed in early 2017/18.

The procurement of a new community beds model has been a significant piece of work during 2017. The mobilisation of the beds from November 2017 will increase system capacity through the winter by 49 beds delivering a flexible bed base for both discharge to assess and intermediate care providing both step up and step down beds with 7 day admission supporting both non-elective admissions and DToC's. Comprehensive mobilisation plans have provided a high confidence in delivery within the timescales. Additional short term winter beds will also be commissioned to support the core bed base, with a further 10 beds secured from 1st November.

In 2017/18 the LIDS may expand to cover more wards across both sites and incorporate a trusted assessor model once additional funding is secured.

5.4 Mental Health

Leeds continues to deliver a rapid bio-psychosocial and risk assessment of individuals who present to A&E with deliberate self-harm and acute mental health problems within 3 hours of referral by LTHT. The crisis café delivered by the Third Sector continues to provide a place of safety as an alternative to A&E supporting social needs and signposting with positive outcomes.

5.5 NHS 111 service developments

Co-ordinated at a regional level the ambition is to roll out NHS 111 Online nationally, increase the clinical input into the triage of patients and when appropriate book patients directly into onward services, Leeds was part of the pilot and we await the evaluation report.

Leeds participated in the pilot for the direct booking of patients from 111 into local GP practices; though the impact was minimal this remains a key national priority and Leeds are keen to support developments at a regional level.

5.6 Primary Care including GP access

We need to recognise that Primary care is also under growing pressure from workload, workforce issues and demand on services.

There is an NHS national ambition and trajectory for delivering extended primary care. Leeds has plans in place to meet these and currently exceeds the national target of 50% with 53% of the population accessing weekend and evening appointments in primary care.

The areas of focus for primary care within the LSDP are to support community capacity especially at times of real pressure. A significant programme of work commenced in 2017 on System Integration and the development of New models of care in Primary Care. This will see GP Practices increasingly working together in groups or hubs. This provides an opportunity to maximise the current skills and services in place to meet patient's urgent care needs. We are working closely with the GP Alliance to scope options for the Leeds Urgent Care Strategy.

5.7 Care Homes

Leeds is significantly involved with the regional care home work led by NHS England. Within Leeds we have developed a cross organisation care home quality group to support standards of care. We also have engaged in several innovative projects including telehealth into 14 care homes, (availability of skype type calls to a clinical support hub in Airedale Hospital) This provides an alternative to care home staff to calling 999 or phoning the GP if a patient becomes unwell or falls. We have implemented a red bag scheme to ensure people have their medication ready if admitted to hospital implemented in all care homes. A red 'book bag' accompanies patients into hospital with standardised paperwork and support for subsequent discharge.

We have strong working links developing with Leeds Care home forums with positive early discussions regarding the development of a care home trusted assessor model. The trusted assessor model would support discharge as a key priority.

In addition a number of primary care schemes from across the city to support care homes is being evaluated to develop a standardised model for 2017/18.

5.8 Urgent Treatment Centres

Alignment of the current urgent care services with the national directive for the development of Urgent Treatment Centres (UTC) is a more strategic ambition in Leeds and sits currently within the Leeds Plan. The ambition will be to deliver urgent care differently integrating extended hours, GP out of Hours, minor injuries services, diagnostics and walk-in-centres into one service.

A full review of the minor injuries and walk-in services has been completed and will be the starting point for the development along with the current primary care hubs working across the city. Analysis of the National guidance and early discussions with providers is ongoing and Leeds feels that it is in a good position to progress the development of a UTC and we aim to redesign one of the Leeds walk in centres to National UTC specification by the end of winter 2017.

5.9 Ambulance response programme

As a pilot site for the national Ambulance Response Programme, Yorkshire has successfully implemented the change in the triage of people and dispatching the appropriate vehicle. This has seen an improvement in the ambulance performance for emergency calls by 8%.

The LSDP continues to maximise opportunities to develop our local ambulance workforce assisting community pathway developments including the Falls Service, Frailty Unit, urgent vehicle services and the development of up to 6 Urgent Care Practitioners in the city for winter 2017/18.

5.10 Public Health

With a focus on self-management, reducing falls and managing outbreaks there are range of public health initiatives that contribute to the effectiveness of the LSDP. These include:

- Leeds City Council (LCC) to commission to deliver Infection Control audits within the care home economy and manage outbreaks of infection effectively.
- LCC facilitate the delivery of infection control training into schools through a workshop and distribution of appropriate promotional material such as hand washing leaflets.
- NHS England to commission Primary Care services, providers and community pharmacies to deliver an influenza immunisation programme targeting at risk groups.
- NHS Leeds CCG, LCC and partners to support promotional campaigns through coordinated communication plans.
- Providers to deliver influenza immunisation programmes for staff.

- LCC to deliver Winter Friends programme, administer Winter Wellbeing Small Grants programme and commission Warmth For Wellbeing service
- Promote Public Health England Cold Weather Plan high impact interventions to the health and care workforce.

5.11 Communications

It is recognised that we need to change the conversation with our population regarding how they access and use services. Building on previous experience and evidence, Leeds will need to agree the conversations with the public regarding the optimal use of services.

The communication plan for 2017/18 will build the use of existing resources and successful social marketing campaigns. By using the same approach to develop focused campaigns for identified target key communities. We will use an insight-led approach to co-produce resources to help people navigate their way around the options available to them.

This approach would look at how we can increase awareness of other urgent care services, what messages would resonate with our identified audiences and give us a better understanding of why some groups of people chose A&E as their first call.

We intend to link with neighbourhood networks during Autumn to communicate the plan and focus on prevention / preparation for winter.

5.12 System management, Escalation and Mutual Aid

Operational Pressures Escalation Levels (OPEL) is the NHS England Mandated framework for all health and care organisations and forms the basis of the Leeds system approach to escalation and mutual aid.

Mutual aid definition

'At its most simple level, mutual aid can be described as people with similar experience and common objectives helping each other to manage and overcome issues.....members both offer and receive support as part of the group'

The overall aim is to provide systematic processes that underpin the management of the system at times surge and capacity pressures. It is essential that we develop a process that is able to identify building pressures in order for us to be proactive and deploy mitigating actions.

Collecting information daily in a consistent way will allow us to collate, analyse and share system wide information to inform organisations, internal and external actions to promote recovery. Adopting this approach will ensure partners work together within agreed escalation processes and a clear principle of mutual aid to support each other will ensure patient care is optimised.

The work stream will:

- Gain assurance that all organisations are compliant with the 2017/18 Emergency, Preparedness, Resilience and Response standards with comprehensive action plans

- Develop a city-wide OPEL Level, understood by all and sensitive to reflect and meet our local needs.
- Align organisational triggers to OPEL to ensure consistency in the interpretation
- Ensure all organisations provide assurance regarding their OPEL levels and internal actions they will take to ensure de-escalation
- Agree the reporting format, analysis and sharing of information
- Develop a data collection process for primary care to assess flow and demand
- Desk top exercise to test process and mutual aid in an escalating scenario, to include adverse weather and flu
- Provide system leaders and clinicians with a mutual aid document with agreed cross organisational actions, Including communications
- Implement a structured approach which drives and supports assurance of a timely system management promoting a recovering system (SiTRep calls)

All of this process will be sufficiently flexible to allow an effective response to a whole spectrum of incidents and events that may create a surge in demand for health and care services, irrespective of situation, duration, scale and type.

The new system management process will be tested through a desk top exercise 21 September and in place for 1 October 2017. The diagram of the proposed system of escalation for Leeds can be found. (Appendix 2)

5.13 Gaps: Areas for further development in 2017/18- 19

The SRAB recognise that there are a number of gaps across the Leeds system where improvements, investments and developments are essential. These include:

- Options to increase EMI community support, capacity and beds
- Urgent community dental services – led by NHS England
- Care home developments – trusted assessor, discharge flexibility
- Live bed state including the independent care home sector
- Securing recurrent funding to expand the Leeds Integrated Discharge Service
- Review of whole system beds capacity and requirement in the next 5 – 10 years
- Further review and development of the Urgent Treatment Centre model for Leeds
- System transport review commenced
- System estates review commenced

6. Monitoring and reporting

The LSDP will be monitored by the ORG through agreed Key Performance Indicators (KPI's) to demonstrate a contribution to the 9 overall system indicators referenced in section 2. Highlight reports will be produced for all areas in the operational plan. (Appendix 4)

6.1 Logic Model Approach

To co-ordinate this effectively a logic model approach has been agreed to provide a diagrammatical view of the plan and demonstrate links across the inputs, initiative/activities, and the 9 system indicators outcomes (Appendix 3). Each initiative lead will be required to

submit a monthly highlight report (Appendix 4) to the ORG providing the group with the tools to monitor the plan and take actions to maximise impact, redirect resources or scope further opportunities. It is to be noted that there are a number of baselines outstanding for us to be able to confirm our trajectory ambitions but an assurance that these will be in place October 2017.

A monthly high level overview will then be produced for the SRAB to provide system assurance by monitoring progress against the 9 system indicators, escalating unresolved issues and managing system risk.

7. Resourcing the Local System Delivery Plan

This year 2017/18 there is no CCG non recurrent financial allocation to the SRAB for winter initiatives, as has occurred in previous years.

Without any additional funding the success of the plan is dependent on our commitment to enable collaborative working across organisations to maximise existing investment, capacity and ensure resources are used effectively and efficiently to support quality experiences for our population.

There will be a focus on new ways of working across localities, communities and acute settings to ensure people receive the care/response they need first time and when appropriate enable them to retain their independence where appropriate.

An excellent example is the current development of a frailty service for Leeds that is under development through the Action on A&E programme. This involves all partner organisations, including the Third Sector working together to deliver a frailty pilot to inform a new service model for winter.

All initiatives within the LSDP have been assessed for cost impact and resource solutions agreed, with the exception of the Frailty service which requires evaluation before seeking further funding. The Leeds integrated discharge service has funding secured up to August 2018 with the IBCF spring budget money supporting the Hospital to home element over the next three years.

8. Risks

The high level risks and mitigating actions to support the delivery of a resilient health and care system in 2017/18 are identified within 2 areas:

- Variable risks are those which we cannot predict but where we can put mitigating plans in place, 8 high level risks have been identified.
- Impact risks are those we have assessed and highlighted the probabilities and consequences of the risk, 7 high level risks have been identified

The high level risks have been RAG rated pre and post the agreed mitigating actions, the full risk register for the LSDP are included in Appendix 5.

9. Conclusion

Leeds has taken a far more proactive approach this year to planning for those predictable challenges that face our health and care system. Evaluation of previous winters has informed the LSDP along with national guidance although it is recognised that there are many varying factors identified within the section 8 system risks that will support or impede the success of the plan.

We can provide assurance that for 2017/18 there are agreed system wide initiatives in place with robust monitoring, clear lines of accountability and overall system commitment to work in an integrated way to deliver care for patients and achieve performance targets.

Glossary

BCF – Better care fund
CCG – Clinical commissioning Group
DTC – Delayed transfer of care
ED – Emergency department
ECS – Emergency Care Standard
EDAT – Emergency duty assessment team
EMI - Elderly mentally infirm
EPRR – Emergency preparedness resilience & response
HWBB – Health and wellbeing board
KPI – Key performance indicator
LCC – Leeds city council
LDSP – Leeds system delivery plan
LTHT – Leeds teaching hospitals trust
LCH – Leeds community healthcare
LYPFT – Leeds & York partnership foundation trust
LIDS – Leeds integrated discharge service
ORG – Operational resilience group
OPEL – Operational resilience escalation level
PEG – Partnership executive group
STP – Sustainability and transformation plan
SiTREP – Situation report
SRAB – System resilience assurance board
UTC – Urgent treatment centre

Appendices

Appendix 1 Leeds system delivery plan- operational plan
Appendix 2 Stages of escalation
Appendix 3 Logic model
Appendix 4 Highlight report example
Appendix 5 Risk register



Report of: Leeds Health and Care Partnership Executive Group (PEG)

Report to: Leeds Health and Wellbeing Board

Date: 28 September 2017

Subject: Leeds Health and Care Quarterly Financial Reporting

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ 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:

This report provides the Health and Wellbeing Board with an overview of the financial positions of the health & care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1). It also provides a briefing on the work being carried out across the West Yorkshire and Harrogate Sustainability and Transformation Partnership (WY&H STP) on developing plans for financially sustainable service delivery models.

Key headlines at quarter 1:

- NHS partners are predicting that they will meet the financial targets set by national regulators. However this is heavily dependent on the identification and delivery of local savings, planned for the latter part of the year.
- Within the City Council, the prediction is that actual expenditure will exceed budget by £2.9m, with this adverse variance relating to the Children's and Families directorate.
- There is significant financial risk associated with the plans of all partners. Savings from the programmes in the Leeds Plan are currently not expected to materially contribute to mitigating the risks in the individual plans of each partner.
- Further citywide action is required to mitigate the risks in single organisation plans.

Recommendations:

The Health and Wellbeing Board is asked to:

- Review the Leeds health & care quarterly financial report.
- Note the work being carried out across West Yorkshire and Harrogate seeking to develop plans for financially sustainable service models

1 Purpose of this report

- 1.1 This report provides the Health and Wellbeing Board with a brief overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide quarterly financial report (Appendix 1). It also provides a briefing on the work being carried out across the WY&H STP on identifying financially sustainable service delivery models.
- 1.2 This financial 'health check' aims to clarify where the current and expected financial pressures are in the local health and care system. This provides the Health and Wellbeing Board with an opportunity to direct action which will support an appropriate and effective response.
- 1.3 This paper supports the Board's role in having strategic oversight of and both the financial sustainability of the Leeds health and care system and of the executive function carried out by the Leeds Health and Care Partnership Executive Group.

2 Background information

- 2.1 In September 2016, the Leeds Health and Wellbeing Board considered a paper entitled 'Towards Better Joint Health and Care Working – A Governance Update'. The Health and Wellbeing Board endorsed a number of proposals within this paper, which included that:
 - o The Board has a principal role in the oversight of the financial sustainability of the Leeds system
 - o The Board oversee the Leeds Health and Care Partnership Executive Group (PEG) which exists 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
 - o The Board receive a quarterly report from the PEG, providing a financial health check for Leeds health and care provision.
- 2.2 The financial information contained within this report has been contributed by Directors of Finance from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Groups.

3 Main issues

- 3.1 At quarter 1 the collective health and care system in Leeds is predicting an end of year adverse variance of £2.9m. This relates solely to the Children's and Families directorate and is being driven by higher than expected demand than was assumed in the budget.
- 3.2 The plans of all partners include significant risks, some of which are currently unmitigated. This particularly relates to the identification and delivery of local savings schemes that are planned to provide significant benefits in the latter part of the year.

- 3.3 The programmes within the Leeds Plan are at different stages of development both in terms of their governance and the identification of any financial benefits for the system and any investment upon which it relies. Savings from these programmes are not expected to materially contribute to mitigating the risks in the local plans of partner organisations.
- 3.4 All organisations in the WY&H STP have recently refreshed their financial plans for the next 4 financial years, 2017/18 to 2020/21. On paper this appears to show that at an aggregate level across the STP, the solutions being developed in each of the 6 places, Bradford and Airedale, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, are sufficient to meet the financial challenge facing them. However each organisation has identified significant risks either associated with delivery of their own plans or where these plans do not align with those of their health and care partners.
- 3.5 It is important that we have credible financial plans that system leaders across WY&H both understand and have confidence in. They need to be underpinned by realistic and overt assumptions about what is driving the financial challenge in health and care, for example, changes in demography, demand for particular services, any staff pay increases and so on. They also need to be realistic in terms of the solutions being planned. For instance, assumed levels of efficiency savings that can be made by provider organisations need to be set in the context of benchmark data from similar organisations elsewhere. Equally, any commissioner proposals to change access to services needs to be supported by evidence from other places.
- 3.6 The STP leadership team have secured some external support from the York Health Economics Consortium (YHEC) to support each of the 6 places in developing plans to deliver financially sustainable health and care services. The team from YHEC are working with system leaders in each of the places through a series of local engagement events and small task and finish groups. The intention is that the outcome of this work will be presented to the broad group of system leaders at an event on 3rd October.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 Development of the Leeds health & care quarterly financial report is overseen by the Directors of Finance from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Groups.
- 4.1.2 Individual organisation engage with citizens through their own internal process and spending priorities are aligned to the Leeds Health & Wellbeing Strategy 2016-2021, which was developed through significant engagement activity.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 Through the Leeds health & care quarterly financial report we are better able to understand a citywide position and identify challenges and opportunities across the health and care system to contribute to the delivery of 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', which underpins the Leeds Health and Wellbeing Strategy 2016- 2021.

4.3 Resources and value for money

- 4.3.1 Whilst the Health and Wellbeing Board has oversight of the financial stability of the Leeds system, the PEG has committed to 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. Bringing together financial updates from health and care organisations in a single place has multiple benefits; we are better able to understand a citywide position, identify challenges and opportunities across the health and care system and ensure that people of Leeds are getting good value for the collective Leeds £.

4.4 Legal Implications, access to information and call In

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

4.5 Risk management

- 4.5.1 The Leeds health & care quarterly financial report outlines the extent of the financial challenge facing the Leeds health and care system. These risks are actively monitored and mitigated against, through regular partnership meetings including the Citywide Director of Finance group and reporting to the PEG and other partnership groups as needed. Furthermore, each individual organisation has financial risk management processes and reporting mechanisms in place.

5 Conclusions

- 5.1 Whilst in 2016/17 all health and care partners in the city met the required financial targets this was due to non-recurrent benefits rather than sustainable changes to operational delivery. For the 4 years 2017/18 to 2020/21, whilst on paper Leeds in common with many of the other places in the STP, comes close to delivering a breakeven position, these plans are not sufficiently robust to be considered credible either to national leaders or to staff and service users. Action is being taken across the WY&H STP to remedy this situation and Leeds is playing its full part in this work.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Review the Leeds health & care quarterly financial report.
- Note the work being carried out across West Yorkshire and Harrogate seeking to develop plans for financially sustainable service models

7 Background documents

- 7.1 None



How does this help reduce health inequalities in Leeds?

An efficient health and care system in financial balance enables us to use resources more effectively and target these in areas of greatest need.

How does this help create a high quality health and care system?

Driving up quality depends on having the resources to meet the health and care needs of the people of Leeds. Spending every penny wisely on evidence based interventions and ensuring we have an appropriate workforce and can manage our workforce effectively promotes system-wide sustainability.

How does this help to have a financially sustainable health and care system?

It maintains visibility of the financial position of the statutory partners in the city

Future challenges or opportunities

Future updates will be brought to the Health and Wellbeing Board as requested and should be factored into the work plan of the Board.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)

A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds Health and Care Partnership Executive Group
Forecast end of year financial position as at 30th June 2017

Appendix 1

1. Section 1 - City Summary

Sign convention – negative numbers = ADVERSE variances

End of year forecast	Total Income/Funding			Pay Costs			Other Costs			Total Costs			Net surplus/(deficit)		
	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Leeds City Council	611.6	617.3	5.7	142.8	141.5	1.3	468.8	478.7	- 9.9	611.6	620.2	- 8.6	-	- 2.9	- 2.9
Leeds Community Healthcare Trust	143.3	143.1	- 0.2	101.6	103.7	- 2.1	38.7	36.4	2.3	140.3	140.1	0.2	3.0	3.0	-
Leeds Teaching Hospitals NHS Trust	1,208.8	1,208.8	-	684.3	684.3	-	515.4	515.4	-	1,199.7	1,199.7	-	9.1	9.1	-
Leeds & York Partnership Foundation Trust	150.5	150.5	-	109.6	109.6	-	37.3	37.3	-	146.9	146.9	-	3.7	3.7	-
Leeds North CCG	289.6	289.6	-	2.8	2.8	-	286.8	286.8	-	289.6	289.6	-	-	-	-
Leeds South and East CCG	421.3	421.3	-	2.8	2.8	-	418.5	418.5	-	421.3	421.3	-	-	-	-
Leeds West CCG	474.5	474.5	-	3.7	3.7	-	470.8	470.8	-	474.5	474.5	-	-	-	-

The 3 NHS Trusts are assuming that they will achieve their control totals. Risks relate to the identification and delivery of local savings plans with a significant proportion of these being planned towards the latter part of the year; the management and risk share in respect of mental health out of area referrals; and potential stranded costs relating to competitive tendering. The CCGs are assuming that business rules will be met, with the main risk again being related to the identification and delivery of local savings plans. For the City Council, the forecast adverse variance relates solely to the Children's and Families directorate.

Savings from the programmes in the Leeds Plan are not expected to materially contribute to mitigating the risks in the individual plans of each partner.

2. Section 2 – local variances, risks and mitigation

a. Leeds City Council

The numbers quoted above relate solely to the Adults and Health directorate (which now includes Public Health) and the Children's and Families directorate.

Adults and Health are forecasting a balanced position in 2017/18 at the first quarter. The budget for the directorate has been adjusted for the additional monies allocated by the Chancellor in the Spring budget although at this stage detailed plans have not been determined or approved. Outside of this additional funding, the main variations for the directorate are staffing (projected saving of £1.3m) which is offset by projected shortfalls in income, including client contributions to community support services. A small underspend is projected for Public Health

The budget for Children's and Families contains a number of significant financial risks and at the first quarter an adverse variance of £2.9m is forecast. Although the 2017/18 budget provided for an additional £3.3m for budgets for looked after children, the directorate is projecting a £3.3m overspend in these budgets being driven by higher demand than anticipated in the budget. The forecast does take account of a number of directorate actions to review external placements and independent foster care packages. The budget for transport is currently forecast to underspend by £0.2m. A shortfall in income in children's centres of £0.5m is forecast and is expected to be offset by additional Education Support Grant being higher than budgeted.

b. Leeds Community Healthcare Trust

The Trust is forecasting that it will achieve its control total of £3.0m surplus. At quarter 1 savings of £0.5m more than has currently been identified are required to achieve this position; action will be taken to deliver this in the second part of the year if the forecast position has not improved. Significant financial risk arises from competitive tendering of services, for example there are unbudgeted redundancy costs that may arise from the decommissioning of services as part of the CIC bed tender. Material financial risk also arises from potential non-delivery of CQUINs and continuing to deliver safe services in periods of increased demand.

c. Leeds Teaching Hospitals Trust

At the end of June, the Trust reported an adjusted deficit of £11.3m, which was £3.6m better than plan. Income is now £6.1m behind plan (principally due to lower than planned activity), offset by a favourable expenditure variance of £9.8m (including technical adjustments). The favourable expenditure position is driven mainly by non-pay which is £10m better than plan. Of that, £4.5m relates to drugs, blood and devices that are contracted for on a 'pass through' basis, this being a major contributor to the adverse variance on income but neutral to the Trust overall. At this point in the year, the Trust continues to forecast that it will achieve the £9.1m planned surplus, with a revised financial framework due to be introduced in late July to manage the current gap.

d. Leeds and York Partnership Trust

The financial position as reported at quarter 1 is within plan tolerances. However, the static run-rate is impacted by the level of unidentified CIP and out of area pressures are flagging the challenge and stretch for later months. The Trust is forecasting to achieve its control total dependent on a number of assumptions, including minimising out of area pressures/agreeing a risk share arrangement with Leeds CCGs and accelerating the CIP pipeline schemes.

e. Leeds CCGs

The CCGs have submitted balanced plans to NHS England for 2017/18, with a citywide QIPP target of 3% (£34.9m) to achieve this position. At this early stage in the year with limited data available the forecast is for a breakeven position. Risks remain regarding system resilience and demand. A key risk is that the QIPP targets remain un-mitigated. For 2017/18 a risk reserve is held to cover this; however the CCGs financial position moving forward is untenable without the realisation of this QIPP requirement.

3. Section 3 – Stock-take on savings from Leeds Plan programmes

The programmes within the Leeds Plan are at different stages of development both in terms of their governance and the identification of any financial benefits for the system and any investment upon which it relies. What follows is a brief stocktake for each.

- The Optimising Secondary Care programme has a steering group meeting on 7th September. At its meeting on 13th June, the SRO asked that each project work up the financial impacts of their work including benefits and any required investments and this work is in progress. .
- The Urgent Care/Rapid Response programme had its first steering group meeting on 6th June and the next is scheduled for 21st August. To date the people involved in this programme have mainly been focussed on the 2017/18 'winter plan'.
- The Prevention programme is continuing to manage the implementation of changes mainly driven by the reduction in funding of the Public health grant. They have set up a new steering group and it meets for the first time on 21st August.
- The Self-management and Proactive Care programme has established a steering group with its second meeting taking place on 16th August. Their priority areas are diabetes; respiratory; frailty; and new models of care, starting with the roll-out of the new musculoskeletal model.
- The Estates programme steering group continues to meet every 6-8 weeks. Their priority is on working up business cases for the 3 priority localities (Burmantofts, Harehills and Crossgates) with a view to being able to demonstrate how practical benefits can be delivered through cross city working. They are planning to have completed this work to come back to PEG in October. They are also supporting the CCGs in their accommodation review and the potential for the co-location of health and social care commissioning staff.
- The Procurement programme steering group also continues to meet every 6-8 weeks. They continue to progress the £3.1m of identified opportunities through the stages of the procurement process. The first project has come to fruition with the letting of a joint contract for taxis between LTHT and LCC. Based on previous levels of activity the new contract will give LTHT a small cost pressure with a saving of c£30k for LCC. Whilst in absolute terms this saving is small, the more significant benefit for LCC is that the contract will give them much greater visibility and control over this c£4.9m area of expenditure and therefore the opportunity to deliver further financial benefits through changes in volumes.
- Following its appearance at the July PEG meeting, the Digital programme is working up proposals to formalise partnership governance and decision making; identify sustainable funding for the joint Strategy, Architecture and Commissioning function; and to establish a city programme budget with clear ownership of benefits realisation and process to manage revenue consequences.

Leeds Health and Wellbeing Board



Report author: Philippa Gibbons (LCC
PPU Senior Project Manager)

Report of: Sue Robins (Director of Commissioning, Strategy & Performance, NHS Leeds CCGs) & Steve Hume (Chief Officer Resources & Strategy, Adults & Health, LCC)

Report to: Leeds Health and Wellbeing Board

Date: 28 September 2017

Subject: Integrated Better Care Fund Plan 2017-19 & Spring Monies

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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
If relevant, access to information procedure rule number:		
Appendix number:		

Summary of main issues

The Integrated Better Care Fund Plan for 2017-19 was submitted to NHS England as required on 11 September 2017 for NHS England to undertake their assurance process of plans. As reported previously the intention was that the Plan would be circulated to the members of the Health & Wellbeing Board prior to its submission to NHS England; however multiple delays in issuing the BCF guidance and the subsequent timetable imposed by NHS England along with issues with the guidance (see paragraph 2.2), meant that this approval had to be taken out of session and a version was not available for circulation prior to submission. As such this report is now presented retrospectively for discussion and approval.

The plan indicates how Leeds will spend BCF, iBCF and Spring Budget monies in both 2017/18 and 2018/19, amounting to £76.5m in 2017/18 and £83.6m in 2018/19, with iBCF and Spring Budget spending also covering 2019/20.

BCF monies will be used to further strengthen integrated working and to focus on preventive services and in particular is focussed on reducing demand on both Social Care and the NHS, particularly on the acute sector.

For the iBCF and Spring Budget monies Leeds is primarily adopting a sustainable 'invest to save' approach with a focus on managing down the forecast increases in the level of demand for funded home care packages, residential/nursing placements and NHS Services.

One of the national conditions under the BCF Plan is the Delayed Transfer of Care (DTOC) metric and specifically the reduction targets for this. At the moment, the NHS England team are advising that as part of the assurance process there will be a review in November of local performance against DTOC trajectories, which could result in the clawback of resources in 2018/19 from the Spring Budget Monies.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of this report
- Note and approve the BCF Narrative Plan 2017-19 (Appendix 1)
- Note and approve the BCF Financial Planning Template 2017-19

1 Purpose of this report

This report indicates the areas that the BCF Plan is intending to address, the sums of money being invested and the types of schemes that are being supported.

2 Background information

- 2.1 The BCF has now been in place since 2014/15 and this year NHS England have mandated a narrative plan covering the period 2017 to 2019. In keeping with previous plans, the BCF Narrative Plan 2017-19 (Appendix 1) and BCF Financial Planning Template 2017-19 (Appendix 2) contains an account of what has been achieved to date and the key deliverables and schemes supported over the coming two years.
- 2.2 The production of the Leeds BCF Plan has been hindered by a number of factors:
- Delays in the issuance of the national guidance, originally expected in January, actually issued in July.
 - Clear national conflicts in the use of the money, evidenced by the Local Government Association (LGA) issuing draft planning guidance in May, followed by final guidance issued by the Department of Health (DoH) and Department for Communities and Local Government (DCLG) in early July, resulting in the unprecedented step of the LGA and ADASS withdrawing their support of the process.
 - Final guidance lacking clarity and specificity in a number of key areas; expecting local resolution of national political issues, including whether the Spring Budget Monies were in fact solely for funding Social Care Services as initially announced.
- 2.3 In line with the guidance issued by NHS England the plan concentrates heavily on the achievement of health and social care integration and progress against four mandated national conditions and four national metrics. The metrics to be reported on are Delayed Transfers of Care, Non-Elective admissions, Admissions to residential care homes and Effectiveness of Reablement.
- 2.4 The Leeds BCF Plan 2017-19 has been developed within the context and priorities of the Health & Wellbeing Strategy and the Leeds Health and Care Plan.
- 2.5 The Leeds BCF Plan 2017-19 covers the use of the additional iBCF allocation and the more recent Spring Budget monies as well as the existing BCF funds.

3 Main issues

- 3.1 The main BCF budget does not represent additional money and will continue to be used to further strengthen integrated working and to focus on preventive services through reducing demand on social care and the NHS, particularly the acute sector.

- 3.2 The main BCF allocations for 2017/18 and 2018/19 are shown below. Taking the Spring Budget monies into account these figures represent increases of £19.1 million and £15 million on last year's BCF funding and across all funding these figures represent increases of £20.6 million and £27.6million. Total funding contributions have been agreed between the Council and the CCGs as follows:

	2017/18	2018/19	2019/20
Total Local Authority Contribution (exc iBCF)	£9.1m	£9.3m	tbc
Total Minimum CCG Contribution	£51.2m	£52.2m	tbc
Total Additional CCG Contribution	£0	£0	tbc
Total iBCF Contribution	£16.2m	£22.1m	£27.4m
iBCF Contribution (recurrent)	£1.5m	£12.6m	£22.7m
Spring Budget Monies (non-recurrent)	£14.7m	£9.5m	£4.7m
Total BCF pooled budget	£76.5m	£83.6m	tbc

- 3.3 The BCF allocation will be spent in these sectors

	2017/18	2018/19	2019/20
Acute	£10.4m	£10.4m	TBC
Mental Health	£5.8m	£5.8m	TBC
Community Health	£20.5m	£21.0m	TBC
Continuing Care	£0.3m	£0.3m	TBC
Primary Care	£2.1m	£2.1m	TBC
Social Care	£37.2m	£43.8m	TBC
Other	£0.2m	£0.2m	TBC
Total	£76.5m	£83.6m	TBC

- 3.4 The funding contributions and schemes being supported include the continuation of existing schemes from the previous BCF plans as follows:

Scheme	Description and impact
Mental Health	For Mental Health. Commissioners and providers are closely linked to improve mental health services for patients through transformative working. A key example is work to reduce the numbers of out of area placements of mental health patients and the services we provide locally for patients suffering a crisis in their mental health.
CCG Community & Third Sector Service	Third sector and statutory community services that provide support and care:- • within the integrated Neighbourhood Teams • for people with physical and sensory impairments • for people in housing need/NFA awaiting discharge from hospital • for people experiencing bereavement Services that prevent unplanned hospital admissions and facilitate timely discharge. Pro-active care planning with individuals so that contingencies are in place.
Community Beds	Intermediate care beds with a range of providers. New contracts start 1 st November 2017/18 and see the implementation of a recommissioned and expanded model that combines bed-based transfer to assess and intermediate care beds.
Enhancing	Primary care developments with the top 2% high risk and vulnerable

Primary care services	patients on their practice registers. In order to develop services around these patients this funding is used to enhance services to support the management of this patient cohort.
Admission Avoidance-Marginal Tariff/NEL	A number of initiatives including Integrated Discharge Service, assessment units discharging to re-ablement rather than admission
Information Technology	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.
South Leeds Independence Centre	LCC –commissioned integrated intermediate care bed-based service until end October 2017 when this is repurposed under the general Community Beds service above.
Leeds Community Equipment & Telecare Service	Revenue streams for this service.
ASC Community & Third Sector Services	Third sector services including support and respite for carers. Contribution to the LCC Re-ablement Service which in 2017/18 is enhancing its service to provide a four hour response time from notification of hospital discharge to home.
Central Allocations	Protected Social Care spending
Disabled Facility Grant	Means-tested grant to cover the cost of housing adaptations that help disabled people to live independently in their own homes

3.5 A summary of the use of the additional funding made available through the iBCF and the Spring Budget, totalling £51.5m over the next 3 years, is as follows:

- Prevention/Self Care/Self-Management £ 5.5m
- Reducing Pressures on the NHS £ 7.6m
- Stability of the Provider Market £ 1.0m
- Provision for Leeds Health & Care Plan £ 2.0m
- Demand and Demographic Pressures in Social Care £22.7m
- Reducing/Reversing planned reductions in Social Care £15.3m

The above priorities total £54.1m, however, it is expected that this level of over programming can be managed within the overall allocation of £51.2m over the next three years.

3.6 Clearly there is a mix of both recurrent and non-recurrent funding included within the £51.5m above, which has allowed for a mixture of both recurrent and non-recurrent support. For instance, the support to stabilise the local care market identified above is non-recurrent support from the Spring Budget, and further recurrent support is being provided from the Social Care recurrent budget and the recurrent iBCF, including future recurrent fee levels which are currently subject to an ongoing cost of care exercise and the development of a Care Quality Team and associated Leadership Academy within the Local Authority Commissioning Team.

3.7 Prevention/Self-Care/Self-Management: Our major initiatives seek to reduce or delay the need for people at risk of or with emerging health and social care needs to seek statutory social care and health services (all figures shown are 3 year totals):

- Investment in Falls Prevention (£780k)
- Investment in Carers Support Services (£300k)
- Increased capacity in Neighbourhood Networks (£840k)
- Improved Information and Skills Training for people dealing with people with Dementia (£265k)
- Investment in a Positive Behaviour Service to reduce the long term costs of care for supporting young people with challenging behaviours (£750k)

3.8 Reducing Pressures on the NHS: Our initiatives are specifically designed to immediately reduce the pressure on the NHS and are intended to prevent people presenting and/or improving the speed of discharge back into the community:

- Increasing the effectiveness of the reablement service (£680k)
- Development of community based peer support networks for people with Long Term Conditions (£210k)
- Investment in the Community Equipment Service to improve the speed of discharge (£1.1m)
- Continuation of the Age UK Hospital to Home Service (£735k)
- Additional investment in Social Work support on hospital wards during the winter period (£490k)
- Investment in the Social Work Rapid Response Service to reduce admissions and improve DToC's on weekends (£200k)
- The development of a frailty assessment unit (£1m)
- Implementation of the Trusted Assessor model at both LGI and St James' (£1m)
- Contribution to the development of the YAS Emergency Care Practitioners scheme. (£750k)

3.9 Demand and Demographic Pressures in Social Care: The iBCF increases announced in the 2015 Spending Review are being utilised to maintain the provision of Social Care Services in Leeds and are therefore funding demand and demographic pressures, particularly in relation to supporting people with a Learning Disability, as well as the impacts of inflation and the National Living Wage. These pressures amount to an annual pressure of in excess of £12m on the Adult Social Care Budget.

3.10 Reducing/Reversing planned reductions in Social Care: A significant portion of the Spring Budget funding allocation will be used to reverse/obviate the need for budget savings that would otherwise have been inevitable. These would have had a significant impact on care packages and the funding of our nationally recognised preventative services, including the older people's Neighbourhood Networks and community mental health provision, equivalent to around 500,000 hours of home care or 15,000 care home bed weeks. Such budget savings would have had a serious impact on Leeds citizens ready for discharge from hospital and on DTOC metrics.

3.11 Of the four national conditions:

- Jointly Agreed Plan: Representation from BCF Delivery Group attended the Health and Wellbeing Board on 24th July to confirm the arrangements for the plan, improved better care fund and DFG.

- Social Care Maintenance: Agreement reached which recognises that as a partnership the need for additional resources to be made available to Social Care in 2020/21 when the additional Spring Budget money ceases and no further increases in iBCF are anticipated.
- NHS Commissioned Out of Hospital Services: The BCF will commission out-of-hospital services to the value of £26.3m. Analysed as:
 - o Mental Health £ 5.8m
 - o Community Health £17.6m
 - o Continuing Care £ 0.3m
 - o Primary Care £ 2.1m
 - o Other £ 0.5m
- Managing Transfers of Care: There is significant investment in this area and in the wider adoption of the High Impact Change Model.

3.12 Of the four national metrics:

- DTOC: there is a robust plan in place to achieve the target reductions in delays attributable to both health and social care. Leeds has received early indication from NHS England that there is likely to be significant focus and scrutiny of DTOC trajectories in the assurance process.
- Non-elective Admissions (NEA): Historically Leeds has failed to meet the targets set for reductions in this, although this position has been impacted significantly by local coding changes to activity in the acute sector and this will continue to be a challenge.
- Re-ablement: There is a focus on improving this through both re-ablement initiatives and the Community Beds strategy.
- Admission to Care Homes: the Leeds approach differs to the national strategy as explained further below.

3.13 The Leeds strategy is to maximise the independence of its citizens through a preventative strength-based approach to social care and linking people to the existing assets in their own communities. One intended outcome of this strategy is that the demand for care home placements will be levelled by maximising the time that people can be supported in the community. The metrics stipulated by DCLG for the iBCF returns are at odds with this, but they have recognised that local metrics that better reflect local aims can be adopted. We are therefore adopting metrics of:-

- 1) number of bed weeks of residential/nursing care commissioned (as opposed to the number of placements in residential) and
- 2) number of home care hours relative to residential (non-nursing) care bed weeks

3.14 The NHS England assurance process required that the Plan was submitted on 11 September. Plans will then be reviewed and either approved with agreement to

spend being issued from early October, or approved with conditions in which case an updated plan will be required by late October. Section 75 agreements are to be in place by end November.

- 3.15 The Leeds Health and Care partnership will be undertaking a review of the BCF plan development process to identify lessons that can be learnt and applied to future partnership working. In addition, the partnership will ensure that any business cases and investments for change are robust, with measureable benefits and outcomes, whole system impacts understood and with a clear transfer to business as usual processes in place.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 The Health & Wellbeing Strategy and Leeds Health and Care Plan were developed in conjunction with partners and stakeholders from across various health and care providers and commissioners, as well as Healthwatch Leeds, third sector and local area Community Committees (local public meetings led by councillors across the city).
- 4.1.2 The BCF Plan has been developed to facilitate the delivery of the Leeds Plan. The BCF Plan has been developed by the BCF Delivery Group in conjunction with the BCF Partnership Board, Integrated Commissioning Executive and System Resilience and Assurance Board. These partnership boards/groups bring together representatives from the statutory health and care partners to help inform shared strategic decisions.

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. Each scheme is responsible for undertaking any equality and diversity impact assessments if relevant in accordance with local policies and processes.

4.3 Resources and value for money

- 4.3.1 Whilst the existing 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.
- 4.3.2 Additional funding has been made available through the iBCF and the Spring Budget, totalling £51.5m over the next 3 years. Some of this has been used to obviate budget savings that would otherwise have been inevitable. These would have had a significant impact on the levels of care packages and placements the

Council was able to provide and could have potentially reduced the level of support available for preventative services in Leeds. However, significant investments have still been possible into prevention and early intervention services, together with a significant investment to reduce the pressure on the NHS, not only during this coming winter, but also in the medium term in support of our aspirations for a sustainable Health & Social Care system in Leeds. Support to stabilise the local care market is prioritised within the recurrent Adult Social Care Budget in Leeds.

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 BCF Partnership Board and Delivery Group, alongside the Systems Resilience Assurance Board are responsible for managing any risks to the delivery of the plan. Mitigating actions to counter identified risks have been put in place.

4.5.2 The main risks identified in relation to the BCF are as follows:

- Workforce issues have a negative impact on delivery of services
- Schemes geared towards reducing non-elective admissions do not have the level of impact that is expected
- Failure to achieve non-elective admissions targets

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 2017-19. Furthermore, the continued journey of sustained transformation sits within the Leeds Health & Wellbeing Strategy, the Leeds Health & Care Plan and the West Yorkshire & Harrogate Health and Care Partnership and. The continued support and commitment of key leaders in the city is critical to the delivery of all the above and the BCF will have a role in this through the services that it supports.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of this report
- Note and approve the BCF Narrative Plan 2017-19
- Note and approve the BCF Financial Planning Template 2017-19

7 Background documents

None

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How does this help reduce health inequalities in Leeds?

The BCF Plan explains how Leeds will spend BCF monies to advance the implementation of the Health & Wellbeing Strategy and the Leeds Health and Care Plan.

How does this help create a high quality health and care system?

See above

How does this help to have a financially sustainable health and care system?

See above

Future challenges or opportunities

See above

**Priorities of the Leeds Health and Wellbeing Strategy 2016-21
(please tick all that apply to this report)**

A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

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**Leeds Clinical Commissioning
Groups Partnership**



Leeds Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

Version: V1.0

Area	Leeds Health and Wellbeing Board
Constituent Health and Wellbeing Boards	Leeds City Council
Constituent CCGs	Leeds Clinical Commissioning Groups Partnership

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	11th September 2017
Date of BCF Planning return	11th September 2017
Value of pooled budget 2017/18	£76,493,789
National conditions	Actions and plans to meet national conditions are in place

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1. Introduction / Foreword

The Leeds BCF Plan for 2017-2019 builds upon the strong integrated working that has already been put in place in the city, as a result of previous BCF initiatives and the development of both the Leeds Health & Wellbeing Strategy and Leeds Health and Care Plan (Leeds Plan). All of which have been developed in accordance with the Integration and Better Care Fund Policy Framework, local Government Transformation and the context of the NHS Five year Forward View

The vision for Leeds through the Health and Wellbeing Strategy and Leeds Plan is that by 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. It is a plan that will improve health and wellbeing for all ages and for all of Leeds which will

- Protect the vulnerable and reduce inequalities
- Improve quality and reduce inconsistency
- Build a sustainable system within the reduced resources available

The BCF Plan for 2017-2019 underpins the Leeds Plan, focussing on its key workstreams of :

- Prevention – “living a healthy life to keep myself well”
- Proactive Care and Self-Management – Health and care services working with me in my community”
- Optimising Secondary Care – “Hospital care only when I need it”
- Urgent Care and Rapid Response - “I get rapid help when needed to allow me to return to managing my own health in a planned way”

whilst ensuring that the additional funding for social care allocated through iBCF and the Spring Budget monies will be well spent in relation to current local system pressures and supporting development of sustainable services.

The funding contributions and schemes being supported include the continuation of existing schemes from the previous BCF plans. A summary of the use of the additional funding made available through the iBCF and the Spring Budget, totalling £51.5m over the next 3 years, are as follows::

• Prevention/Self Care/Self-Management	£ 5.5m
• Reducing Pressures on the NHS	£ 7.6m
• Stability of the Provider Market	£ 1.0m
• Provision for Leeds Health & Care Plan	£ 2.0m
• Demand and Demographic Pressures in Social Care	£22.7m
• Reducing/Reversing planned reductions in Social Care	£15.3m

The above priorities total £54.1m, however, it is expected that this level of over programming can be managed within the overall allocation of £51.2m over the next three years.

Clearly there is a mix of both recurrent and non-recurrent funding included within the £51.5m above, which has allowed for a mixture of both recurrent and non-recurrent support. For instance, the support to stabilise the local care market identified above is non-recurrent support from the Spring Budget, and further recurrent support is being provided from the Social Care recurrent budget and the recurrent IBCF.

This BCF Plan along with the other related plans has been developed in conjunction with a broad range of 'supporters' and has been signed off by the Leeds Health & Wellbeing Board.

2. What is the local vision and approach for health and social care integration?

Vision

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 place-based values to succeed in achieving this.

We have a nationally recognised Leeds Health and Wellbeing Strategy 2016-2021 which we are looking to deliver in large part through the Leeds Health and Care Plan (known as the Leeds Plan), our city's place-based component of the West Yorkshire & Harrogate Sustainability & Transformation Plan (STP).

Both the Leeds Plan and the STP result in a set of other initiatives to deliver their stated aims which are described in more detail below. The Better Care Fund plan (BCF) underpins the system and initiatives as indicated in sections 5 and 6.

1. Leeds Health and Wellbeing Strategy¹

The Leeds Health and Wellbeing Strategy 2016-2021, and has the vision that:

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

The Strategy has identified five key outcomes which are the conditions of wellbeing we want to realise for everyone in Leeds:

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

¹ [Leeds Health and Wellbeing Strategy](#)

To achieve this vision the city will focus on twelve key priorities. It is recognised that to deliver many of the priorities the city will need to focus on transforming services including where necessary integrating services to ensure that people with long term care needs are supported to stay well. Other strategies and action plans will be developed to provide further detail on how specific parts of the citywide vision will be achieved over the next five years.”

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 £'.



Transformation and Integration of Services

West Yorkshire & Harrogate Sustainability and Transformation Plan (WYSTP) Leeds City Council²

In recognising the value and potential of more shared working across the region, Leeds has actively worked with other areas of West Yorkshire to develop a shared West Yorkshire and Harrogate Sustainability and Transformation Plan (WYSTP)

The WYSTP is underpinned by six place based implementation plans. The Leeds Plan is the Leeds contribution to the WYSTP and describes how Leeds will deliver the requirements contained within the NHS Five Year Forward View whilst at the same time focussing on local priorities as agreed through the Leeds Health and Wellbeing Strategy

The Leeds Health and Care Plan (Leeds Plan)³

The development of the Leeds Plan provides us the opportunity to place the BCF within an overarching longer term strategy and ensure it does not operate in isolation from other initiatives in the city. The Leeds Plan sets out ideas about how we will improve health outcomes, care quality and financial sustainability of the health and care system in the city. The plan recognises the Leeds Health and Wellbeing Strategy 2016-2021, its vision and its outcomes, and begins to set out a plan to achieve its aims.

The plan recognises and references the collaborative work done by partners across the region to develop the West Yorkshire and Harrogate STP, but is primarily a Leeds based approach to transformation, building on the existing strategies that promote health and inclusive growth in the city. Whilst the financial challenge is a genuine one, the Leeds approach remains one based on long term planning including demand management, behaviour change and transition from expensive acute services towards community based approaches that are both popular with residents and financially sustainable.

A transition towards a community focused model of health is intrinsic to the plan through the system integration work. This is the major change locally and will touch the lives of all people in Leeds. This 'new model of care' will bring services together in the community. GP practices, social care, third sector and public health services will be informally integrated in a 'primary care home'. Our hospitals will work closely with this model and care will be provided closer to home where possible, and as early as

³ A3 Version of the Leeds Health and Care Plan on a Page

possible. New tools, known as 'Population Health Management' will be used to ensure the right people get the right services and that these are offered in a timely fashion. This is designed to prevent illness where possible and manage it in the community.

The development of the Leeds Health and Care Plan has been supported by partners and stakeholders from across various health and care providers and commissioners, as well as Healthwatch Leeds, third sector and local area Community Committees (local public meetings led by councillors across the city). Conversations have also taken place over the last year about how best to align the citizen conversation about health and care in Leeds with 'Changing Leeds'

A significant amount of engagement activity has taken place when the Leeds Health and Wellbeing Strategy was being refreshed. This is alongside ongoing engagement activity on strategic decision making which occurs across the activity of the Leeds Health and Wellbeing Board and its constituent members. All of this has helped shape the Leeds Health and Care Plan.

As statutory organisations across the city working with our thriving third sector 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. The plan has been improved through engagement with a wide range of stakeholders and will continue to develop through further conversations with citizens. 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.

Our Leeds Health and Care Plan is 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 2016-2021. It is a plan that will strive to improve health and wellbeing for all ages and for all of Leeds, but where people who are poorest improve their health the fastest. 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 and sees citizens, families and communities as the co-producers of health and wellbeing rather than the passive recipients of services.
- Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment.
- Identifies what has the potential to improve health and wellbeing the fastest including what already works well in an area and the opportunities provided by digitalisation to improve connections and promote integration.
- Further develops prevention and early intervention and uses neighbourhoods as a starting point to help integrate social care, hospital, third sector and

community services to provide care closer to home and a rapid response in time of crisis.

- Supports individuals' mental health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships and services working to tackle physical and mental health together.
- Values, empowers and helps grow our own workforce from our diverse communities and involves them in the co-production of any changes.
- Understands the importance of the economy, housing, employment and environment in generating health.

The Leeds Plan has been developed within the context of the Integration and Better Care Fund Policy Framework, local Government Transformation and the need to develop plans within the context of the NHS Five year Forward View and associated publications.

The vision for Leeds Health and Care Plan is that by 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. It is a plan that will improve health and wellbeing for all ages and for all of Leeds which will

- Protect the vulnerable and reduce inequalities
- Improve quality and reduce inconsistency
- Build a sustainable system within the reduced resources available

The ambition for the Leeds Plan is for our community health and care service providers, GPs, local authority, hospitals and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that:

- Have citizens at the centre of all decisions and change the conversation around health and care
- Build on the strengths in ourselves, our families and our community; working with people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong
- Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens
- Use neighbourhoods as a starting point to further integrate our social care, hospital and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis
- Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do
- Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire

Models of Care

Population Health Management⁴

Leeds is moving to an approach that focusses on population level outcomes. A system Blueprint for Population Health Management (PHM) has been developed, and is due for sign-off in September 2017. The Blueprint describes our vision and plans for commissioning for outcomes and integrated provision in Leeds, building on Leeds's strengths with regard to partnership working and place-based care. The Blueprint has been co-produced through a process of engagement.

The definition for Population Health Management (PHM) adopted by Leeds recognises that health and wellbeing is more than just being 'without disease'. It moves away from managing disease in silos to an approach based on defined populations of people, who may have multiple 'disease conditions' or life challenges. It provides a framework for the whole population across all age groups.

In Leeds, PHM is described as:

- Improving population outcomes through a whole system approach where commissioners and providers work together to define, measure and improve population outcomes.
- Designing, organising and integrating the full cycle of care around the needs of a population group by moving away from organisational silos towards jointly accountable/local care.
- Supported by a strategic approach to commissioning which measures and values delivery of key outcomes for defined population segments, rather than the traditional emphasis on processes, pathways and activities.
- Fully utilising informatics solutions to direct care interventions to where they are most needed, and better support professionals in joint working.

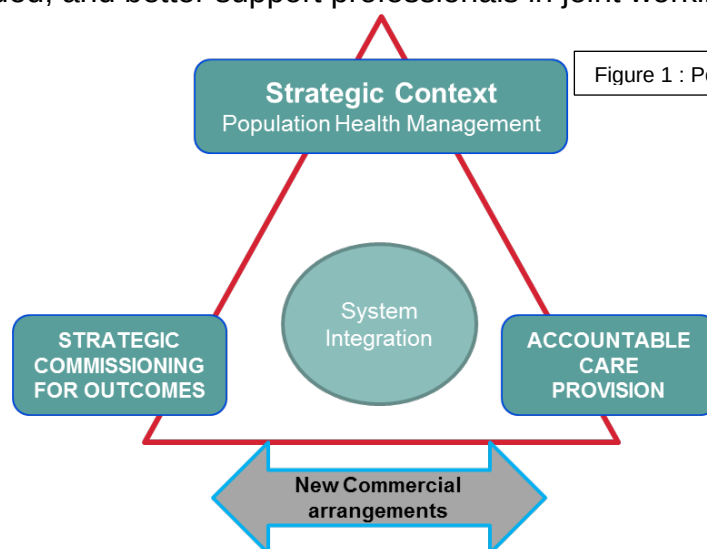


Figure 1 : Population Health Management Approach

⁴ Leeds system Blueprint for Population Health Management (not published)

To achieve the vision of the Leeds Health and Wellbeing Strategy and address the three gaps identified within “Next Steps on the NHS Five Year Forward View” (Health and Wellbeing, Care and Quality and Funding and Efficiency) there is a need for Leeds, to simultaneously balance the need to:

- 1) Continue to deliver pathway level re-design.
- 2) Actively support new models of joint accountability between providers
- 3) Co-produce the conditions for providers to work in partnership by adopting a PHM approach focussed on improving outcomes for the population.
- 4) Approach this by understanding the needs of broad groupings (or segments) of the population and using this understanding to set high level outcomes.

Other Models of Care

In addition to PHM we are aiming to achieve the extended primary care neighbourhood model of health and care delivery with local care partnerships being established.

Across Leeds there are a multitude of new models of care being tested at neighbourhood or locality level. These ‘test-beds’ have developed, bottom up to respond to local population need. Positive progress in a number of key areas has been made, Living Well Leeds; Primary Care based musculoskeletal services and the Neighbourhood Leadership Model; and provide examples of where good practice can be achieved.

We are also seeing the further development of providers coming together to establish joint accountability arrangements to respond to gaps in care (for example: GPs in A & E, Extended Access to Primary Care and “Primary Care Home” – enhanced neighbourhood teams.)

Leeds has an opportunity to strengthen governance and strategic plans to drive the level of system change desired. The blueprint proposes a combined ‘twin approach’ to take forward PHM: System-Led adoption of PHM and Organic, bottom-up Pathway/provider focussed.

The system will deliver a reduction in acute activity (Delayed Transfers of Care (DTOCS), admissions, readmissions, Length of Stay (LOS), excess bed days).

Housing Strategy 2016 - 2021

The Health and Wellbeing Strategy acknowledges that housing is a wider determination of health and consequently needs to be addressed to allow the vision to be realised. The Leeds Housing Strategy sets out our ambition for effectively meeting

the needs of those in greatest housing need over the next 5 years. The vision and delivery of the strategy is to: Effectively meeting affordable and social housing need, promoting independence and creating sustainable communities to make Leeds the best place to live.

The plan to deliver the strategy:

- Neighbourhood Approach – targeting particular neighbourhoods with a wraparound service that meets the wider needs of residents and the neighbourhood, not just the housing need;
- Focus on Prevention – ensuring that suitable levels of support are available from an early stage to enable residents to live confidently and independently in their home;
- Collaborative Working – We have well established and strong relationships with our key partners in order to jointly deliver this strategy;
- Building Community Resilience – empowering communities to support themselves through closer working with community led and third sector organisation.

Six key themes have been identified as priorities within the strategy including: “Meeting the needs of older residents” – Ensuring that the right housing options are available which allow older people to remain active and independent in their homes and communities. To support this a range of key services are available :

- Minor adaptations to homes in all housing sectors to ensure that residents can maintain independence and remain living in their place of choice;
- Hospital discharge service to support residents to return home or to a new home that meets their needs
- Healthy aging programmes offering training and guidance for staff working with communities on issues such as falls prevention, nutrition and hydration and winter wellbeing
- Promoting Social Inclusion by encouraging residents to remain active and link in with community activities, e.g. activities such as lunch clubs, chair based exercise in sheltered housing schemes and the Neighbourhood networks.

Disabled Facilities Grant (DFG)

Leeds is a significant provider of DFG which is a contributing factor in allowing people to return home. Significant demand for this has led to prioritisation of the DFG grant on integrated technology projects that support health and social care professionals in supporting vulnerable adults to retain their independence and remain in their own homes for longer. These include the development and roll out of the nationally acclaimed Leeds Care Record and the development of a unique Person Held Health & Care Record, as well as supporting the delivery of the Digital Roadmap for Leeds.

Local Plans

Leeds has also developed a range of shorter term plans that underpin the WYSTP. Examples include the CCG's Operational Plans and the Leeds A&E Delivery Board Plan.

National Picture

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 22/12/2015, NHS England (NHSE) published the 'delivering the Forward View: NHS Planning guidance 2016/17 – 2020/21'.⁵

The BCF contributes to the 12 priority areas which have been identified in the Health and Wellbeing Strategy. Too often care is organised around single illnesses rather than all of an individual's needs. Leeds is focusing on making care services more person-centred, integrated and preventative. All organisations will be working together to achieve this alongside the local communities and individuals. The diagram below illustrates the approach Leeds takes to work together.

Objectives of the Better Care Fund Partnership

The key objective of the Better Care Fund Partnership will be to underpin the priorities outlined within the Leeds Plan with a focus on developing integrated services that proactively support patients to manage their conditions. Our approach aims to deliver the following:-

- Reduce the need for people for emergency admissions to hospital
- Ensure that people only stay in hospital as long as necessary for their care
- Reducing dependency on long term care, residential with or without nursing care
- Maximising community assets

Our Integration and Better Care Fund Plan builds on the work already undertaken within the BCF ensuring consistency with The West Yorkshire and Harrogate STP and Leeds Health and Care Plan (Leeds Plan).

⁵ [Delivering the forward view: NHS Planning guidance 2016 - 2021](#)

3. Background and context to the plan

Leeds is the UK's third largest city with a population of around 750,000. It is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population (2011 census). It is also one of the greenest cities in the UK with 20 major parks and two thirds of the district as rural.

The population is expected to rise to around 840,000 by 2021, with an increase in the numbers of children of primary age as well as the numbers of those aged over 75 and over 85.

Nationally a 14% increase ⁶in the number of people living with dementia is expected between 2016 and 2020, driven by prevalence of the condition in the over 75's and improved diagnosis. This would equate to an increase in numbers living with the disease in Leeds from 8,500 today to 9,600 in 2020-21. However with the emergence of health inequalities as risk factors for dementia the outturn in Leeds could be underestimated.

Dementia-related disability is forecast to increase by 49% in the next ten years (England and Wales), partly because of increasing numbers with the condition and partly increasing levels of need experienced by people with dementia. This emerging trend is already observed by local service providers.

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

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

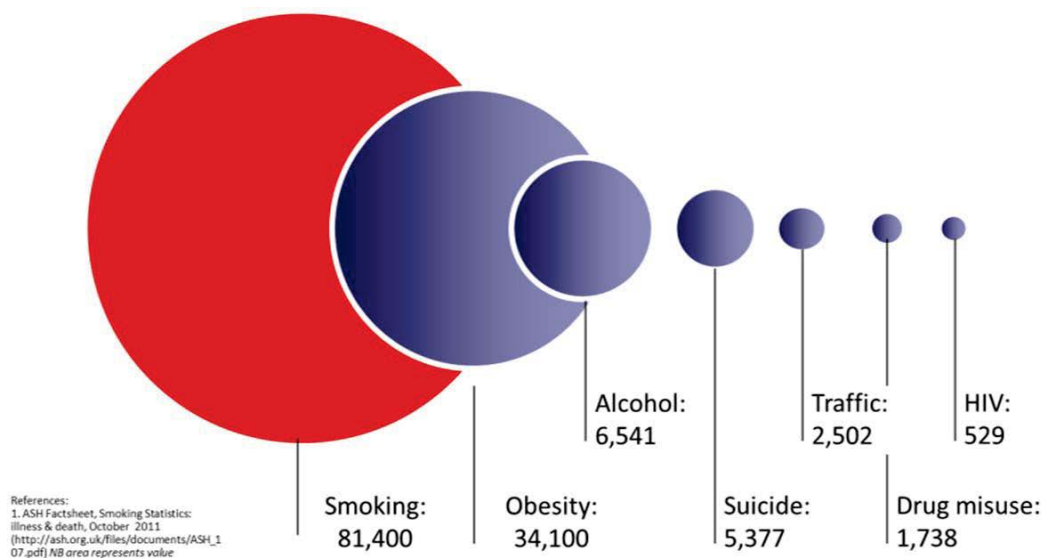
The aging population along with combined with growing number of people living with long term conditions is creating significant pressures on the health and social care system within Leeds. The Leeds system is experiencing demand growth for emergency care of between 2% and 3% per year with acuity of patients increasing as the population increases.

⁶ <http://www.bmj.com/content/358/bmj.j2856>

As more people develop long term conditions, we recognise the need for health and care services to adapt to managing health conditions which empower individuals to manage better their conditions and ensure where appropriate, health and care providers take a proactive care approach.

Long term conditions can lead to a reduced quality of life and premature death, but are preventable. Figure 2 (below) shows the causes of preventable death in England):

Figure 2.



In previous years Leeds has used the BCF to take forward its stated vision for health and social care. Today that vision is driven by the Leeds Plan and the BCF schemes are aligned to it and enable its delivery.

Current State of Health and Social Care Market:

The current state of the Leeds social care market is covered in detail in the [Leeds Market Position Statement 2015-18 \(revised June 2017\)](#). In Leeds we have a diverse and vibrant care and support provider market, with a good mix of third and independent sector organisations, and small as well as larger providers. The mix of providers does differ by type of service, for example preventative services are predominantly delivered by third sector organisations, whereas residential and nursing care services for older people are largely provided by the independent sector. This diversity is positive for the city and provides service users with greater choice. Maintaining a vibrant and diverse market is a priority for us.

Key trends in the market place are the continued move away from residential to supported living provision for working age adults. For older people the preference remains to be able to support people to live independently for as long as possible, with residential provision being required for those with more complex needs.

Key Issues and Challenges

Suitable workforce.

Workforce and Organisational development has been recognised as a key issue and forms one of the enabling workstreams under the Leeds Plan.

Locally the recruitment and retention of nursing staff within public sector organisations remains a challenge and has the potential to be exacerbated by European nationals leaving due to Brexit and its associated uncertainties.,

Allied to this is a demographic challenge around local General Practitioners, where a number are approaching the age where they could elect to take early retirement which would place a significant capacity restraint on the healthcare system.

Leeds is a signatory to the Ethical Care Charter which recognises the value of care staff and the promise of a living wage. This has been incorporated into new care contracts awarded by the Council in June 2017.

Funding

Funding of both health and social care remains a significant concern. In Leeds a significant portion of the Spring Budget iBCF funding allocation will be used to reverse/obviate the need for budget savings that would otherwise have been inevitable. These would have had a significant impact on care packages and the funding of our nationally recognised preventative services, including the older people's Neighbourhood Networks and community mental health provision. Such budget savings, equivalent to around 500,000 hours of home care or 15,000 care home bed weeks, would have had a serious impact on Leeds citizens ready for discharge from hospital and on DTOC metrics

4 Progress to date

Leeds City Council and Leeds Health Commissioners have a long history of joint working to support the development of out of hospital care. The city has well established integrated health and social care teams based on localities.

To date Leeds BCF Plans have included a range of initiatives designed to provide better health and care services, closer to home, with the aim of reducing the demand

for urgent and emergency care and the need for expensive hospital beds and residential care home placements. This was extended in 2015/16 to cover plans for out of hospital care.

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

- Reablement services
- Supporting Carers
- Leeds Equipment Service
- Falls prevention
- Enhancing Integrated Neighbourhood Teams
- Community Matrons
- Expanding Community Intermediate Care beds
- Urgent Care Services
- 3rd sector prevention
- Admission avoidance
- Disabled Facilities Grant
- Enhancing Primary Care

Whilst we have successfully implemented our initiatives they have not to date had the impact that we had hoped in certain areas (eg. Non Elective Admissions (NEA)). In particular the demand for emergency care has continued to rise, with the Leeds health and social care system experiencing similar issues to those across the majority of the UK i.e. increasing numbers of A&E attendances and emergency admissions, ongoing non-delivery of the A&E 4-hour standard and cancellation of elective surgery leading to non-delivery of the referral to treatment and cancer 62-day treatment standards.

Other Health and Care Integration

In addition to all the integration activities described in section 2, together, and separately both the Local Authority and CCG's have moved towards closer integration. From April 2017 Leeds City Council brought all its 'people commissioning' functions together into the Adults and Health Directorate, and the formation of the Leeds Clinical Commissioning Groups Partnership across the Leeds CCG's supports integration begun with the "One Voice Programme" which established a single leadership team across the three CCG's and streamlined commissioning functions through:

1. Establishing a Strategic Commissioning function, integrating previously separate commissioning teams and functions.
2. Establishing a System Integrator (SI) function to proactively establish a PHM approach by facilitating a move to commissioning for population

level outcomes alongside the development of providers to delivery level outcomes through accountable care arrangements.

At the same time, providers across the city are working together more closely than ever before through the Leeds Provider Network which includes representation from all providers including the Third Sector and General Practice.

The commissioners and providers in Leeds are signed up to making System Integration happen and the Health and Wellbeing Board, and the Partnership Executive Group (PEG) have committed to the change.

CCG Operational plan

In December 2016 Leeds CCG's submitted their two year operational plans. These plans outline the CCG's service and financial plans for the period 2017 – 2019. The plans provide assurance to NHS England as to how CCG's will meet key national priorities over the period along with details on the alignment of the CCG's plans with the priorities identified by the wider health and care system such as the West Yorkshire and Harrogate STP and the Leeds Plan.

The CCG Operational Plan includes the CCG finance and activity trajectories for Non-Elective Admissions (NEA's).

In July 2017 the CCG activity plans were recalibrated to take account of changes with national categorisation of services between NHS England and CCGs.

The CCGs are confident that their Non Elective plans are robust and affordable; they have been signed off by NHS England as part of their assurance process. As such the BCF submission for Non-Elective Admissions will be consistent with those of the CCG.

Former National Conditions

Leeds continues to work to those BCF national conditions that were stipulated in 2016/17 but which NHSE have not carried forward as formal BCF conditions for 2017/18 and 2018/19:-

Delivery of 7 day services – agreement for the delivery of this is still in place following the improvement from an 'in-progress' position in Q3 2016/17. The Leeds Transfer of Care Group, under the auspices of the Leeds A&E Board, is responsible for continued delivery of the 7days principles through Leeds' implementation of the High Impact Change Model.

Better data sharing – Leeds continues to use the NHS number as a common identifier. We have a proven track record of interoperability between systems, as

evidenced by the Leeds Care Record. The use of APIs remains a key strategic principle. We have now established a joint Local Authority and CCGs' Integrated Business Intelligence service which is driving this agenda further. We continue to ensure that our Information Governance remains in line with revised guidance and to keep the public aware of their rights in this respect and informed of how their data is used.

Joint approach to assessment and planning – Leeds continues this approach through its investment in the further development of the Leeds Care record. The newly established Leeds Integrated Discharge Service (LIDS) streamlines and accelerates the transfer from hospital care to appropriate community services. The Trusted Assessor approach, driven through the High Impact Change Model has led to an upskilling within the hospital, with a joint approach towards assessment for the enhanced Reablement Service (four hour at home response for hospital discharges).

Consequential impact on providers – the overall Leeds Plan approach and governance is joint between Health and Social Care commissioners and providers. This allows individual projects to be worked through in terms of unintended consequences and ensures that actions do not destabilise providers or effect service delivery to Leeds citizens.

Performance Against Key Metrics

Non-elective admissions (NEA)

Performance against the NEA target continues to be a challenge. Our aim of stemming growth in non-electives is proving difficult. The nationally reported figures, as derived from SUS, appear to show considerable growth. However, this does not reflect the reality as the national figures do not take account of local coding changes. Leeds has over the last two years changed the way it codes those patients admitted to the Clinical Decision (short stay assessment) Unit from A&E. The table below outlines growth with and without the inclusion of the change of coding i.e. those patients admitted under the A&E specialty to the Clinical Decision Unit

Financial Year	Activity	A&E Coded Activity	Activity Net of A&E	Activity Growth including A&E %	Growth without A&E admissions %
2014/15	66673	7087	59586		
2015/16	71772	10707	61065	7.6%	2.5%
2016/17	77112	16210	60902	7.4%	-0.3%

Once these changes are taken into account our growth rate is much lower and shows a growth of 2.5% in between 14/15 and 15/16 and 0% in the last financial year (16/17). This reduction reflects significant work undertaken to change ambulatory care pathways with a focus on avoiding admissions.

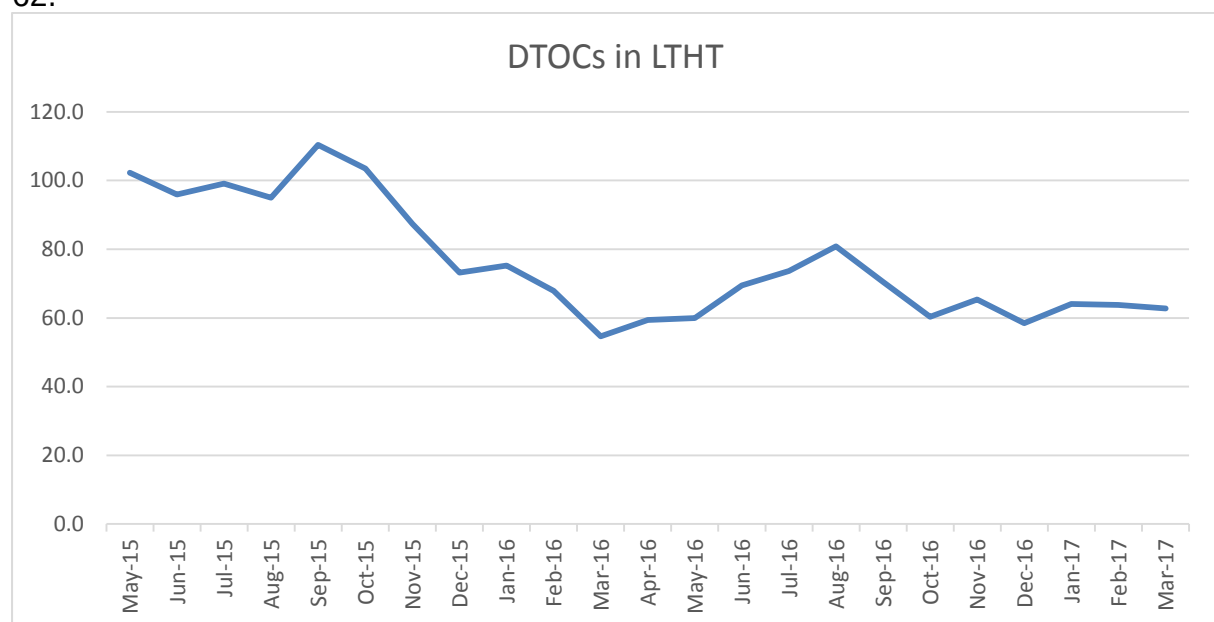
It should be noted that whilst recorded admissions are showing a year on year decrease there remains significant pressure for beds. In recent years the total number of non-elective bed days has grown year on year in line with that expected by demographic changes i.e. around 2%. It is this growth in bed usage that is placing significant pressure on local NHS Hospitals.

The aim for 2017/18 is to maintain the impetus on avoiding admissions through changes in front door A&E streaming and through increasing focus on proactive community management of patients with Long Term Conditions.

Delayed Transfers of Care (DTOC)

In Oct 2016 Leeds established an integrated discharge service on 10 acute medical wards. The table below describes the progress the Leeds system has had with respect to reducing the number of delayed discharges in Leeds Teaching Hospitals

The average number of beds occupied by DTOCs has remained relatively stable for the last year. The table below shows that the number beds occupied by DTOCs in any given month has dropped from around 100 in July 2015 to its current level of around 62.



To date our focus has been on maintaining levels of DTOCs in our main teaching hospital. In 2017/18 we will continue to undertake initiatives to support LTH along with focussing harder on other providers.

Our current target is to reduce average DTOCs from around 83 across all providers to an average of 59 DTOCs per day (based on weekly DTOC bed days/7). This would constitute around 25% reduction as compared to the current levels. Plans in place to address current levels include

- a) Maximising potential of new reablement service (live June 19th 2017)
- b) Implement new Community Beds Strategy Inc Transfer to Assess
- c) Build Trusted Assessor Capacity in Integrated Discharge Service
- d) Build on current Care homes Initiatives
- e) Improved streaming in A&E to avoid admission
- f) Renewed focus on supported choice
- g) Focus on DTOCs related to mental Health Issues

Successes

Over the last two years Leeds Health and Social Care system has had some success in reducing the number of DTOCs in Leeds Teaching Hospitals. There are a number of reasons for this which include.

- a) Improved multi agency working between health and care systems
- b) Implementation of new Leeds Integrated discharge Service went live on 9 wards in Leeds teaching Hospitals in November 2016
- c) Improvements in system escalation and mutual aid processes when the system is under pressure

Over Q4 of 2016/17 the levels of DTOCs in LTHT remained fairly consistent at around 62 per week. Whilst this is an improvement on recent winters it remains above our target of 47 for the Trust

We are currently working to build on our work to date to improve further our multi agency working and systems responses to further reduce DTOCs

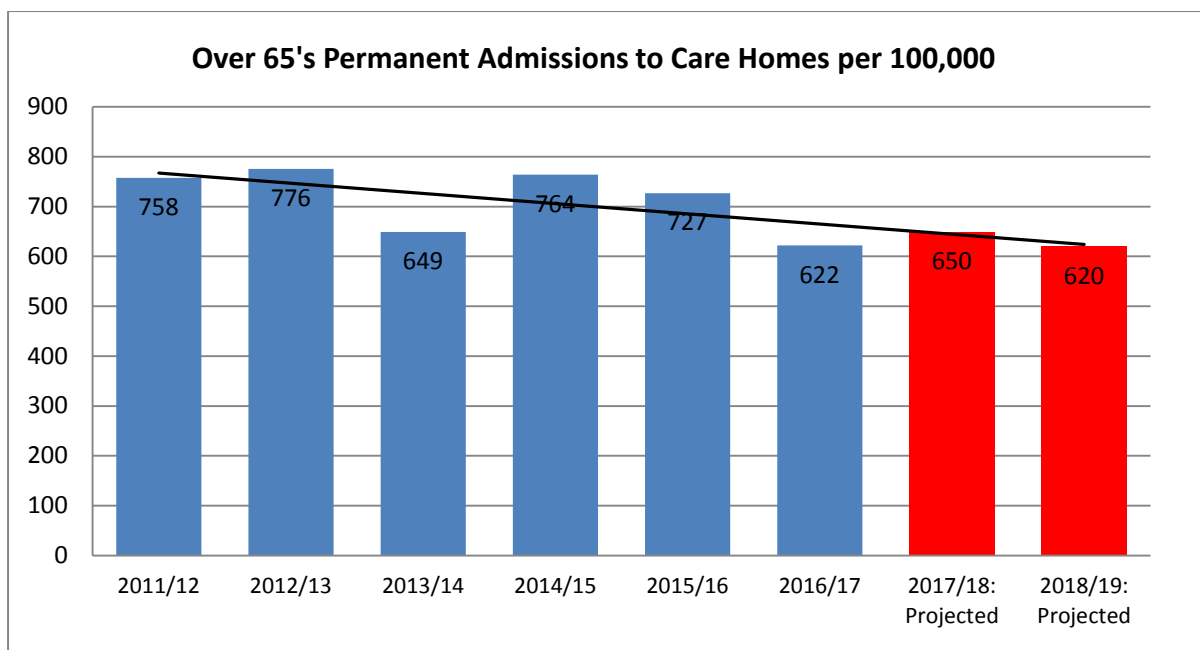
Rate of Admissions

The ASCOF measure looks at the number of admissions in relation to the estimated older people population for the LA. As the population estimates are changed each year by the ONS this measure does factor in and reflect estimated demographic changes.

The BCF target for 2016/17 was 750.4 admissions per 100,000 over 65 (910 actual). The outturn was well below this at 622 admissions.

Top quartile performance for 2015/16 was between 513.3 and 188 admissions per 100,000. The all England average was 628 and the comparator average 760.

The graph below includes conservative projections for 2017/18 and 2018/19 based upon recent trends and should the current direction of travel continue and self-funders continue to be excluded.



Effectiveness of Re-ablement

Skills for Independent Living (SkILs) is Leeds City Council's home care reablement service which has been developed from what was the Council's in house home care service. SkILs became a city wide service in January 2012 and the service been under continued review and changes made since its introduction with a major restructure and change in the route through the service, though not to the customer group it is focussed on, implemented in June 2017.

Homecare reablement is seen as a key service to support system flow – with a particular focus on the service facilitating discharge from hospital where the person has an opportunity to make further recovery but does not require clinical interventions.

The majority of the budget is spent on staff, with £3.8m on the front line support workers. The delivery of the service is supported in operations by senior support workers, case officers and managers. There is also a business support team which is critical in managing the rostering of staff and ensuring visits to customers are carried out and collecting and reporting on service performance. The service is registered with CQC and has recently been inspected and was found to be "Good" on all domains.

The Needs Identification Tool (NIT) was introduced in June 2017 as part of the new service model which involves Case Officers from the service visiting the person referred to reablement and carrying out an assessment and identifies the individual's

potential to benefit from the service and if so, leads to creating a Personal Outcomes Plan. Previously in the Leeds service, the assessment and outcomes were designed by the health or social care assessor making a referral to the service, but issues with flow – described below – led to the redesign of the pathway to get people into the service more efficiently.

The service has a Budget Action Plan every year and is also reported on through the Leeds Adults and Health Social Care Performance and Outcomes Framework.

The latter reports the following performance for 2015/16 and 2016/17

Measure		15/16	16/17
10	The number of people starting a service	1532	1827
10a	The number of people completing a service	1363	1717

The reporting for 2017/18 has been complicated by a change of service model at the end of quarter 1. While the new model is not designed to change the eligibility of people who receive reablement, it is designed to identify more of those people who do meet the entry criteria, get them into service and move them on at the end of the intervention more quickly.

The Targets for starters and completers in 2017 is

Starters 3,427

Completers 3,060

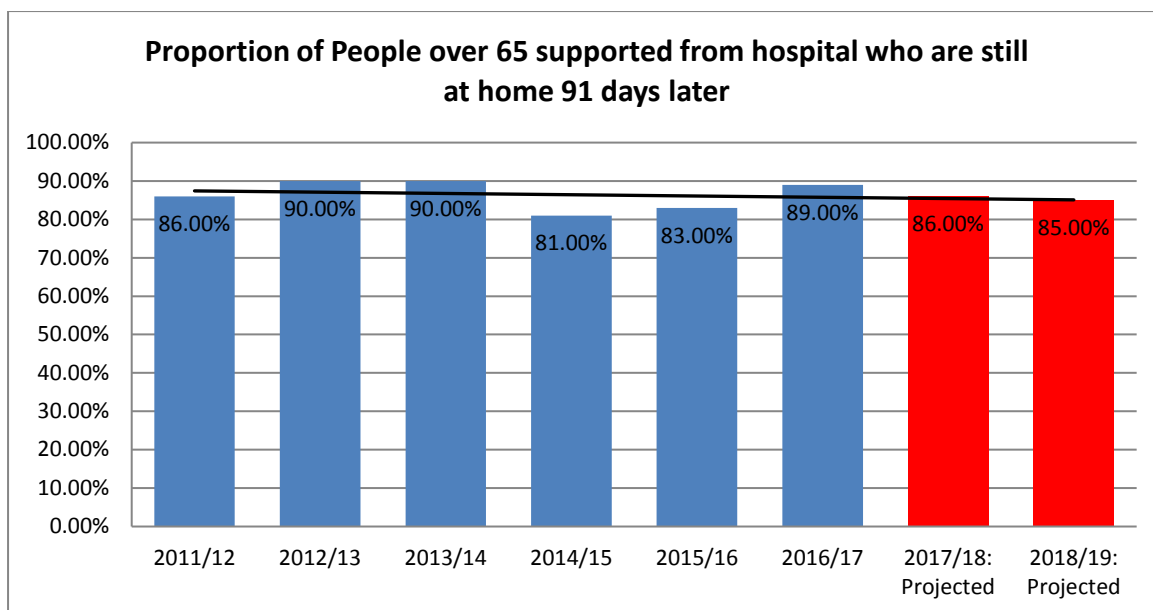
The benefits expected from the redesigned service are detailed in section 11.

ASCOF Measure 2B(1): Reablement – Proportion of people over 65 supported from hospital who are still at home 91 days following discharge

This ASCOF measure includes people who have completed reablement and a check has been undertaken by SKiLs staff 91 days following completion. In addition data is obtained through Caretrak. This includes people with social care involvement leaving hospitals that are further supported through ICT. Caretrak looks for any hospital, residential or other activity up to 91 days after discharge.

The target for the BCF 2016/17 was 92.5%.

Top quartile performance for 2015/16 was between 88.6 and 100%. The all England average was 83% as was the comparator average.



5. Evidence base and local priorities to support plan for integration

The aim for the BCF Plan is to underpin the Leeds Plan and address the challenges and issues detailed in section 4. The BCF Plan for 2017-2019 builds upon and learns lessons from our experiences delivering previous BCF Plans.

Key successes

1. Building on partnership work across health and social care with commitment across agencies to follow this through into the STP programme
2. Safeguarding social care and 3rd sector service provision
3. Further development of IT systems across health and social care
4. Development of the Leeds Care Record
5. The Community Intermediate Care bed strategy

Key challenges

1. Aligning BCF expectations and strategic outcomes to pre-existing service developments and the Leeds transformation programme
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.
3. Reducing NEAs
4. Managing the impact of NEAs on the wider system flow

BCF update:

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. Although we have not been able to meet our targets on NEAs, the BCF programme has helped to strengthen our out of hospital care sector which has 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 people's lives.

Whilst demand for services is within our expected demographic profile, all services are seeing a rise in the complexity of the cases presented and this has had an impact on system flow.

Emergency admissions to hospital provide a proxy measure for the impact of these schemes on achieving the stated objective 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 the previous year's comparator and national average and is deemed a good level of performance for the city.

Our most significant area of success during 2016-17 is the development of the Leeds Care Record. This is now a well-established technology facility across the city that enables the sharing of clinical information between those health and care professionals that are providing direct care to an individual. Those organisations participating are; Leeds Teaching Hospitals, Leeds Community, Leeds and York partnership trust, adult social care, children's services, all GP Practices in Leeds, hospices in Leeds and Yorkshire Ambulance Service. It is actively used by over 4000 health and care professionals.

The Leeds Care Record has been shown to improve clinical decision making, increase the speed by which patients are discharged from hospital and significantly reduced the time making phone calls between organisations. Good feedback has been received from users showing how patients are benefitting from this integrated information. It is a good example of where money has been invested and savings are being made recurrently.

Another significant area of success is our strategy around Community Beds. Longer term commissioning investment has been secured to improve and enhance community bed-based capacity, in readiness for winter. Capacity will be increased from 179 beds to 227 beds (factoring in demographic growth up to 2019/20). The beds will cater for both Intermediate Care and a new Transfer To Assess model. The capacity will meet existing demand as well as meeting the needs of:-

- Additional patients from the community who can't access a Community Bed due to lack of capacity (equivalent to 158 admissions avoided per year)
- at least 50 patients currently waiting in hospital for residential or nursing beds based on Medically Fit For Discharge Data; excludes patients waiting to go home or for complex care - equivalent to 12,500 hospital bed days per year and 4500 excess bed day payments.

A 'hospital to home' service has been maintained but has been integrated further into an Integrated Discharge Service within LTHT working with Discharge Nurses, Therapists and hospital Social Workers. The service continues to evolve and ongoing development reports into the System Resilience Governance.

The biggest challenge we have faced is reducing non-elective admissions and managing the impact of NEAs not reducing. Whilst a change in coding practice in the Acute Sector has impacted on this, we also know that underlying growth is a contributing factor.

The BCF Plan for 2017-19 largely continues with the initiatives from previous years, building on successes, addressing challenges and increasing capacity and reach.

iBCF

The strategic direction that the city of Leeds has mandated Adult Social Care to take is to maximise the independence of its citizens through a preventative strength-based approach to social care and linking people to the existing assets in their own communities. Everything is geared towards ensuring that people's independence is maximised and thus their reliance on statutory services is minimised with a focus on:-

- Maximising people's potential through recovery and re-ablement
- Maximising the benefits of existing community assets and Neighbourhood Networks
- Improving the application and uptake of technology

One intended outcome of this strategy is that the demand for home care packages will be levelled or even reduced by directing the service towards people with more complex needs (yet requiring more hours individually), and the demand for care home placements will be levelled by maximising the time that people can be supported in the community. The metrics stipulated by DCLG for the iBCF returns are therefore at odds with this. Indeed, we would view a reduction in these metrics as a sign of success. We recognise that these metrics have been selected at a national level based on an assumption that all areas would view the funding of more care packages as the route to improved system flow and, in particular, reduced DTOCs. However, the funding of these packages is not an obstacle to system flow in Leeds and our investment in improving DTOC performance will focus on the agreed priorities identified through the HICM as detailed above. We are pleased therefore that you have recognised local variation such as this by inviting us to use local metrics that better reflect what we aim to achieve in Leeds whilst still satisfying the purpose and conditions of the grant. We are therefore adopting metrics of:-

1. number of bed weeks residential/nursing care commissioned (as opposed to the number of placements in residential) and
2. number of home care hours relative to residential (non-nursing) care bed weeks

6. Better Care Fund plan

BCF Funding for 2017 - 2019

The BCF allocations for 2017/18 and 2018/19 are shown below. These figures represent increases of £3.2 million and £10.2 on allocations last year. Funding contributions have been agreed between the Council and the CCGs as follows:

	2017/18	2018/19	2019/20
Total Local Authority Contribution (exc iBCF)	£9.1m	£9.3m	tbc
Total Minimum CCG Contribution	£51.2m	£52.2m	tbc
Total Additional CCG Contribution	£0	£0	tbc
iBCF Contribution (recurrent)	£1.5m	£12.6m	£22.7m
Spring Budget Monies (non-recurrent)	£14.7m	£9.5m	£4.7m
Total iBCF Contribution	£16.2m	£22.1m	£27.4m
Total BCF pooled budget	£76.5m	£83.6m	tbc

The BCF allocation will be spent in these sectors

	2017/18	2018/19	2019/20
Acute	£10.4m	£10.4m	TBC
Mental Health	£5.8m	£5.8m	TBC
Community Health	£20.5m	£21.0m	TBC
Continuing Care	£0.3m	£0.3m	TBC
Primary Care	£2.1m	£2.1m	TBC
Social Care	£37.2m	£43.8m	TBC
Other	£0.2m	£0.2m	TBC
Total	£76.5m	£83.6m	TBC

The Leeds Better Care Fund pooled budget comprises eleven schemes organised into two funds. Fund 1 contains services whose commissioning is hosted by the Leeds CCG partnership and Fund 2 contains services whose commissioning is hosted by Leeds City Council.

Table below –overview of commissioned schemes in the Leeds BCF

Pooled Fund	Scheme	Description and impact
Fund 1: CCG funded services	Mental Health	Transformation of mental health services is aligned to the Leeds Mental Health Framework and the National Five Year Forward View For Mental Health. Commissioners and providers are closely linked to improve mental health services for patients through transformative working. A key example is work to reduce the numbers of out of area placements of mental health patients and the services we provide locally for patients suffering a crisis in their mental health.
	CCG Community & Third Sector Service	Third sector and statutory community services that provide support and care:- • within the thirteen integrated Neighbourhood Teams • for people with physical and sensory impairments • for people in housing need/NFA awaiting discharge from hospital • for people experiencing bereavement • Services that prevent unplanned hospital admissions and facilitate timely discharge. • Pro-active care planning with individuals so that contingencies are in place
	Community Beds	Intermediate care beds with a range of providers. New contracts start 1 st November 2017/18 and see the implementation of a

Pooled Fund	Scheme	Description and impact
		recommissioned and expanded model that combines bed-based transfer to assess and intermediate care beds.
	Enhancing Primary care services	Primary care developments with the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding is used to enhance services to support the management of this patient cohort.
	Admission Avoidance-Marginal Tariff/NEL	A number of initiatives including Integrated Discharge Service, assessment units discharging to re-ablement rather than admission.
	Information Technology	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.
Fund 2: Council Hosted Services	South Leeds Independence Centre	LCC –commissioned integrated intermediate care bed-based service until end October 2017 when this is repurposed under the general Community Beds service above.
	Leeds Community Equipment & Telecare Service	Revenue streams for this service.
	ASC Community & Third Sector Services	Third sector services including support and respite for carers. Contribution to the LCC Re-ablement Service which in 2017/18 is enhancing its service to provide a four hour response time from notification of hospital discharge to home.
	Central Allocations	Protection of social care including contributing to the cost of packages of care and the financial costs associated with the Care Act.
	Disabled Facility Grant	Means-tested grant to cover the cost of housing adaptations that help disabled people to live independently in their own homes

For detail of the individual services within the schemes, please see Appendix 1

Schemes and Impacts

The Leeds Better Care Fund Plan is a contributor to Leeds' wider plans for health and wellbeing and system integration.

Whilst ensuring that the Leeds BCF-funded initiatives meet the relevant BCF grant conditions, the Leeds Plan provides the strategic context for prioritising the spend and also takes account of the actions needed to deliver the High Impact Change model. Leeds is targeting its BCF funding at initiatives that the city has collectively identified, with Leeds City Council and the Leeds CCGs Partnership agreeing proposals with local NHS commissioners via the joint Leeds BCF Partnership Board.

Viewed in this context the BCF will support the Leeds Plan programmes and enablers as follows:

Prevention:

Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens.

- a) City Wide Health Living Services that target prevention on those populations with the poorest health and therefore greatest opportunity for improvement will

be repocured by LCC Public Health services. We will target populations with high levels of smoking, obesity and substance misuse to ensure that we reduce the associated harm and address health inequalities.

- b) We are continuing with our locality based working and initiatives, to address the broad issues that contribute to health inequalities. We will have a new, locally-based community service, 'Better Together', that can better build everyday resilience and skills in our most vulnerable populations.

Proactive Care and Self-Management:

Over the next three years we will change how services are delivered so they are focussed on supporting people to manage their own health and keep as well and independent for as long as possible. We want to help our local health and care economy spend less than it currently does overall by re-distributing this money to services that focus on prevention, self-management and proactive care in the community – GP surgeries, district nursing services, social care services, as well as voluntary/charitable organisations that are such an important part of our city.

- a) Self-Management: Systematic implementation of the House of Care framework, as the integrated approach to embedding supportive self-management for physical and mental health LTCs (inc. dementia).
- b) New Models of Care: CCGs and NHS Providers are working with Leeds City Council to progress a number of pilots across Leeds to assess potential future models for the integration of primary and community care around natural communities. The aim is to provide seamless care closer to home that maximises opportunity for patients to stay well whilst minimises the duplication of demands across a range of health and social care provision.
- c) Maximise the potential of Neighbourhood Network Schemes, these are community based, locally led organisations that enable older people to live independently and pro-actively participate within their own communities. They provide services that reduce social isolation, provide opportunities for volunteering and act as a "gateway" to advice/ information services, all to promote the health and wellbeing and thus improve the quality of life for individuals. Internationally recognised.
- d) Community Bed Strategy: including Transfer to Assess: Leeds CCGs have developed a new strategy for community beds which has been procured and will be operational from 1 November 2017. The strategy builds on evidence of population need and will provide 227 step up/step down beds to ensure that patients either do not need to be admitted to a hospital bed or can be discharged from hospital into a community setting at the earliest possible stage in their recovery, including having their needs assessed. This will support all partners in Leeds in their ability to ensure that patients are provided with the most appropriate out of hospital care for their needs. The service includes a

commitment to adopt the Trusted Assessor approach to bring further efficiencies

- e) Home Development: The city is working in partnership on a range of initiatives to include providing clinical support and training to care homes to avoid admissions and expedite acute discharge (both physical and in the form of telecare). There is also significant work being undertaken to ensure that our market Care development strategy across health and social care supports the future development of the care sector in line with changing demographic needs. The quality of care in the care homes sector has also been highlighted as an area of need this year and the council and the CCG are working collaboratively to improve and monitor the quality of care delivered to patients in care homes.
- f) Right Care: Leeds CCG are working on a number of pathways where there is evidence that our approach to managing conditions in primary and community care is leading to increased non-elective demand on hospitals beds. The key pathways for 2017/18 are respiratory and cardio vascular disease.
- g) Social Prescribing: Leeds CCG and the City Council operate a number of social prescribing initiatives which seek to support patients that may have needs that are not directly health related but impact on demand on health services. These services generally operate as a referral services whereby NHS and Social Care professionals can refer patients for support with issues such as social isolation, housing, benefits and other needs. In 2017/19 Leeds CCGs are seeking to review the social prescribing models currently in operation across Leeds CCGs with the aim of procuring a single citywide model.

Optimising Secondary Care

This is a broad ranging project which focusses on both hospital internal efficiencies as well as how the system supports those efficiencies, ensuring that once patients are admitted they are treated in the most cost effective way.

- a) Development of the Leeds Integrated Discharge Service: This is one element of the Leeds approach to the delivery of the 8 High Impact Changes. It operates in such a way as to embed a number of the key principles e.g. Integrated Teams, Trusted Assessor, Choice and Early Discharge Planning.

Urgent Care and Rapid Response

This programme of work will look to deliver improvements in four areas.

- a) Access: a review of all the single points of access across the city and how patients and the public are informed about and access urgent care services, from Ambulance services, community services, urgent primary care, walk in services and A&E.
- b) Assessment of patients early in their urgent care journey is critical and delivers best results for patients when done with a multidisciplinary team approach. The programme will look at all the current assessment pathways aiming to make improvements to their efficiency and patients experience.

- c) A system wide strategy for urgent care services is in progress across Leeds and this is being linked into the Leeds Plan. The development of GP new models of care and emergent hubs along with extended access is setting the bedrock for a robust urgent care system in Leeds with the strategic direction being to deliver on the NHS aspirations to have Urgent Treatment centres within leeds, open 24 hours a day for walk in, diagnostics and urgent presentations.

In addition the programme will support several other key projects in the City supporting patients presenting with an urgent need:

- d) Redesign of 999, 111 and Ambulance Response services: The review and redesign across West Yorkshire seeks to streamline the mechanisms by which patients access services and identifying the most appropriate services to their needs to avoid unnecessary deployment of ambulance and/or attendances at A&E and admission. This includes initiatives such as hear, see and treat and referral to community services, rapid response teams or primary care
- e) Frequent Attenders Project: A project that reviews those patients that are high users of urgent care services (e.g. 999 and A&E) whose needs could be managed proactively with greater support in community settings
- f) GP Streaming in A&E: Many patients attending A&E could be adequately seen by a primary care service. Leeds has been testing a model where GP's and primary care streaming is delivered within the two A&E units in Leeds. This is in line with National specification.
- g) Frailty Service: Health and Social Care leads have developed an innovative frailty assessment service that has been piloted and will be evaluated. Elderly patients are able to be assessed by a team of professionals specialising in elderly care. Evidence from across the UK suggest that such services support admission avoidance through better understanding and management of the needs of frail patients

Information Technology

During 2017/18 the intention is to use Better Care Funds to further increase the use of the Leeds Care Record and enhance its facilities. The following targets have been set; Increase active usage by another 2000 users, increase the adult social care data that is shared, introduce alerts and notifications to make the system more proactive, improve the patient summary to make key information easier to find, to start 'writing' information in to the record rather than simply displaying information collected elsewhere, increase the medical images available, integrate with an emerging Person Held Record. Progress against these targets will be actively monitored.

Person Held Record

Whereas the Leeds Care Record is a multi-organisational, shared-technology facility to support health and care professionals (doctors, nurses, social workers etc.) it is

recognised that, to improve the whole health and care system and improve overall health and wellbeing, citizens and patients need to have greater awareness and understanding of their needs in order to take more control.

Through access to existing health/care/wellbeing information from across the system and the ability to record information to help inform care professionals and their own needs, it is envisaged that citizens will become more informed and proactive in their care needs and self-management (medications, allergies appointments, letters, care plans etc.).

Using Better Care Funds, Leeds is looking to begin the development of such person-held facilities in a way that establishes standards for such facilities across the NHS. For example, how a patient identifies themselves securely and unambiguously on to a digital facility should be standard across the NHS. We are also aiming to undertake this in such a way so as to encourage software developers to follow such standards to give patients/citizens as much choice as possible around the technology they choose to use. In the first instance, we plan to develop a facility to be used by around 300 diabetic patients in Leeds to record certain information about their own care, share some of this with the Leeds Care Record and receive some information from those professionals that look after them. Leeds will also be collaborating with NHS Digital and Cabinet office (Government Digital Services) to showcase both national verification initiatives and a showcase exemplar of a PHR, aligning with paperless 2020 ambitions set by the Secretary of State.

iBCF

The iBCF increases announced in the 2015 Spending Review are being utilised to maintain the provision of Social Care Services in Leeds and are therefore funding demand and demographic pressures, particularly in relation to supporting people with a Learning Disability, as well as the impacts of inflation and the National Living Wage. These pressures amount to an annual pressure of in excess of £12m on the Adult Social Care Budget. The ongoing cost of care is currently being reviewed in conjunction with local care providers and it is anticipated that an above inflation increase will be required. This will need to be funded on a recurrent basis from within the iBCF allocation.

Spring Budget Monies

Leeds is primarily adopting a sustainable 'invest to save' approach in its use of the Spring Budget funding with a focus on managing down the forecast increases in the level of demand for funded home care packages and residential/nursing placements. This will allow us to fund and monitor the impact of initiatives which contribute to the transformation of the Leeds Social Care and Health system (as articulated in the Leeds Health & Care Plan). This is a sustainable approach over the next three years that will help to us mitigate against future demand pressures from 2020/21 onwards after

the additional iBCF funding reaches its peak and the Spring Budget funding has ceased.

Leeds is targeting its additional Spring Budget funding at initiatives that the city has collectively identified will deliver the stated objectives of iBCF. For both the Spring Budget and iBCF allocations, Leeds City Council has worked with the Leeds CCGs Partnership (the new organisational form of the three Leeds CCGs) and proposals have been agreed with local NHS commissioners via the joint Leeds BCF Partnership Board. This allocation has then been reviewed at both System Resilience Assurance Board and Partnership Executive Group.

£8M of Leeds' £14.7M 2017/18 Spring Budget funding allocation will be used to reverse/obviate the need for budget savings that would otherwise have been inevitable. These would have had a significant impact on care packages and the funding of our nationally recognised preventative services, including the older people's Neighbourhood Networks and community mental health provision. £8M equates to around 500,000 hours of home care or 15,000 care home bed weeks. Such budget savings would have had a serious impact on Leeds citizens ready for discharge from hospital and on DTOC metrics.

With the remaining £6.7M, we have prioritised the following initiatives:-

- Falls prevention service
- Enhancement of Neighbourhood Networks
- Capacity to implement the strengths-based approach to Adult Social Care
- Enhancement to Leeds Community Equipment and Telecare Service
- Retaining care home capacity

Furthermore, we are currently identifying the appropriate Adult Social Care contribution to the following new partnership initiatives that the Leeds system has identified and agreed via the High Impact Change Model process :-

- Frailty Assessment Unit
- Leeds Integrated Discharge Service (Age UK elements)

Leeds City Council has been leading a two year programme to re-procure care home beds for the city which is set to result in the award of new contracts in December 2017. Working with the Leeds CCGs and independent sector care provider representatives, we have recently engaged an independent consultant to conduct a review of provider costs to inform the setting of fees for the new contracts.

Adult Social Care has increased the rates it pays for homecare from June 2017.

The detail of the schemes being supported by the Spring Budget funding are in Appendix 1 these are summarised below:

Area	2017/18	2018/19	2019/20
Prevention/Early Intervention	1,245,754	2,022,006	2,189,987
Reducing Pressure on the NHS	2,539,048	2,894,302	2,179,887
Sustainability of the Care Market	100,000	465,120	465,120
Leeds Health and Care Plan	666,667	666,667	666,666
TOTALS	4,551,469	6,048,095	5,501,660

Our initiatives for prevention and early intervention for those at risk of or with emerging health and social care needs seek to reduce or delay the need for those people to seek statutory social care and health services:

- a) Investment in Strengths Based Social Care Interventions
- b) Investment in Asset Based Community Development Approaches
- c) Improved Information and Skills Training for people dealing with people with Dementia
- d) Investment in Falls Prevention
- e) Investment in Carers Support Services
- f) Increased capacity in Neighbourhood Networks
- g) Investment in a Positive Behaviour Service to reduce the long term costs of care for supporting young people with challenging behaviours

Our initiatives specifically designed to immediately reduce the pressure on the NHS are intended to prevent people presenting and/or speed of discharge back into the community:

- a) Increasing the effectiveness of the reablement service
- b) Improving Nutrition and Hydration for those over 65
- c) Development of community based peer support networks for people with Long Term Conditions
- d) Investment in the Community Equipment Service to improve the speed of discharge
- e) Investment in Telecare smart rooms to demonstrate the effectiveness of Telecare to aid recovery at home
- f) Continuation of the Age UK Hospital to Home Service
- g) Additional investment in Social Work support on hospital wards during the winter period
- h) Investment in the Social Work Rapid Response Service to reduce admissions and improve DToC's on weekends
- i) The development of a frailty assessment unit
- j) Implementation of the Trusted Assessor model at both LGI and St James'
- k) Additional provision for transitional beds for winter 2017/18
- l) Contribution to the development of the YAS Emergency Care Practitioners scheme.

Given the nature of the non-recurrent basis of the Spring Budget funding we have found it difficult to use the funding to directly support the sustainability of the care market, however, as outlined above in relation to our use of the recurrent iBCF we have prioritised ensuring the currency of our fee rates through a cost of care exercise. In addition we have established a Care Quality Team to support Care providers in the city in improving the quality of care provided through advice, support and organisational development opportunities.

7. National Conditions

Signatories to the plan (The Health and Wellbeing Board) have been made aware of the timescales for the creation and submission of the plan for the 11th September 2017. Representation from BCF Delivery Group attended the Health and Wellbeing Board on 24th July to confirm the arrangements for the plan, improved better care fund and DFG.

The Leeds Health and Wellbeing Board is made up of:

- ICE/BCF Partnership Board will review and agree the plan prior to submission to the Health and Wellbeing Board
- Sign off from Cllr Charlwood (Chair of Health and Wellbeing Board will sign off the plan.

The overall approach to the investment of the Spring Budget monies and the criteria adopted was endorsed at a special Leeds Health and Well-being Board workshop in April 2017. The Q1 return which preceded this plan was approved by the Leeds BCF Partnership Board.

Supporting Evidence – links and documents to be included:

- Leeds Plan (Leeds Health & Care Plan)
- Leeds Health and Wellbeing Strategy
- Leeds Health and care System Integration in Leeds
- Best Council Plan
- Leeds Housing Strategy
- 'One Voice' - Developing a vision for General Practice in Leeds
- LCC Breakthrough project – Making Leeds the best place to grow old in
- High Impact Change Model
- 16 / 17 spend and draft 17 / 18 Spend predictions

National condition 2: social care maintenance

As part of our preparations for this plan, we have revisited our position in relation to the maintenance of social care. The Leeds health and care system recognises the importance of capacity within social care to enable the efficient and effective operation of the Leeds health economy. With this in mind, we have reviewed the short and medium plans for social care in Leeds and have determined that the level of support required does not require a change to either the baseline for social care support or changes to the allocations within this plan.

However, in 2020/21 it is predicted that adult social care will face a further significant funding gap. This is recognised as a system wide pressure. We will therefore develop a city-wide agreement between statutory organisations (CCG and Local Authority) which will support and aim for the recurrent release of resources currently tied up in unplanned care including non-elective activity across the city. This contribution of freed up resources from a reduction in unplanned care will be prioritised towards the declared funding gap of £2.8m within Social Care. Agreement to this arrangement will be sought from NHSE to ensure that this commitment is fully understood and associated risks recognised irrespective of any other local changes in NHS organisational structures in the future. This will be ratified by CCG Governing Body and LCC Executive Board. We anticipate that this funding will be released from but not be dependent upon reducing non-elective activity through the work of the BCF up to 2020/21.

Partners across Leeds are committed to developing and delivering solutions to the address the three gaps: health and wellbeing, care quality and finance and efficiency, through the Leeds Health and Care Plan. In developing and delivering those plans, partners are committed to developing a system wide solution to enable this contribution to adult social care to be made.

National condition 3: NHS commissioned out-of-hospital services

The BCF will commission out-of-hospital services to the value of £26.3m. Analysed as:

- Mental Health £ 5.8m
- Community Health £17.6m
- Continuing Care £ 0.3m
- Primary Care £ 2.1m
- Other £ 0.5m

Contingency funds for Non-Elective Admissions have been provided at £7.5m.

As stated elsewhere in this document there is a significant investment in Community Beds to provide out of hospital care.

National Condition 4: Managing Transfers of Care

Ensuring smooth flow between hospital and community services is a key priority for the Leeds health and care system. In recent years the level of focus on systems flow has increased. In 2015 Leeds undertook significant work supported by the then Trust Development Agency (TDA) to understand reasons for delays in discharge from hospital and to support the development of a range of projects to improve flow. The outcome of that work focussed efforts in three key areas

- a) Improving out of hospital capacity to address capacity gaps
- b) Improving coordination of assessment and discharge planning processes within the hospital
- c) Improving communications with external agencies to improve coordination of discharge

Over the last two years the Leeds system partners have continued to build on the work undertaken in 2015. This work has included

- a) Redesign of reablement services to support early discharge. The new models enables the hospital to discharge patients on a trusted assessor model (see later). Patients will be returned home and seen by the reablement team within 4 hours of discharge.
- b) Reprourement of Community Bed Capacity: The Leeds system has undertaken a redesign and tender exercise for a new model of community bed provision. This new model is due to go live in November 2017 and will support the transfer to assess model. This will enable patient to be discharged to a sub-acute setting whilst their ongoing and future needs are assessed.

To support the work on Transfer of Care the Leeds A&E Board have established a Transfer of Care Group (TOC). Over the past 18 Months the TOC Group have focused on developing and implementing the High Impact Change Model.

The TOC group has overseen the establishment of an Multi-disciplinary Discharge Team. This team known as Leeds Integrated Discharge Service (LIDS) brought together a range of professionals previously managed as separate teams into a cohesive admission avoidance and discharge assessment and planning service. The service brings a range of nursing, Physio and Occupational Therapy and social work under one structure to ensure that assessment and discharge planning processes are seamless and coordinated. The model went live on 19th October 2016 and underpins our approach to many of the high impact changes. The focus to date for the LIDS has been on admission avoidance in A&E and admission assessment wards along with 9 medical admission wards A national model has been developed to support CCGs and LA assess where there are in terms of for development towards delivery of the High Impact Changes and to support planning for future. The model describes 5 levels of attainments

- 1) Not yet established
- 2) Plans in place
- 3) Established
- 4) Mature
- 5) Exemplary

The table below summarises our current status with regards to delivering the model

Change	Current Position
Early Discharge Planning	Mature
Systems to monitor patient flow	Plans in Place
Multi-disciplinary/ multi-agency discharge teams	Partly Established
Home first/discharge to assess	Established
Seven day services	TBC
Trusted Assessors	Partly Established
Focus on Choice	Mature
Enhancing health in care homes	Established

Further details on implementation of the 8 high impact changes and future plans are outlined below

Change 1 Early discharge planning. All patients admitted as an emergency/ unscheduled care are assessed and an expected date of discharge is be set within 48 hours. Those patients that require supported discharge are referred to the LIDS Team who coordinate multi agency assessments and plan and arrange discharge. Those that will return to usual residence with no additional support are managed by the wards. Further work is required to extend the LIDS approach to all admission wards

Change 2 Systems to monitor patient flow. Work is being undertaken by the Leeds Operational Resilience Group to develop capacity and demand systems that will enable a daily assessment of peaks and troughs in system flow across all providers.

This analysis will inform the systems OPEL rating. The daily reporting will underpin our approach to escalation and mutual aid whereby all providers will develop plans for supporting systems flow in extremis. Work is beginning undertaken to develop electronic mechanisms to capture data

Change 3 Multi-disciplinary/multi-agency discharge teams, The Leeds system has established a Multi-agency Team known as LIDS which includes staff from acute community social care and community services along with voluntary and community sector. As stated above the service coordinates discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients. The service currently covers medical wards only. Work is being undertaken to understand the options for extending to all wards

Change 4 Home first/discharge to assess. The Local Authority has a range of transitional beds available and has recently implemented changes to the reablement service to support faster discharge. In addition the Leeds Community Beds Service will offer a range of step up and step down 'step-down' beds to bridge the gap between hospital and home meaning that people no longer need wait unnecessarily for assessments in hospital. In addition Leeds have commissioned a Hospital to Home Service from Age UK Leeds which supports the discharge of patients home who need a little short term support to re settle after a temporary acute episode

Change 5 Seven-day service. Leeds has a range of seven day service. We are looking at a range of pathways to establish which services should be working seven days may offer the most benefit in terms of improving quality and systems flow. We are implementing a new respiratory service that will work seven days as a first step in understanding these benefits. Respiratory has been chosen due to the evidence that Leeds has very high levels of admissions due to respiratory disease along with delays in discharge especially over weekends. A workshop is being undertaken to further understand priorities for 7 day working.

Change 6 Trusted assessors. The Leeds system has implemented trusted assessors for a range of services as part of its Integrated Discharge Service. LIDS Team members are trusted assessors for discharges to reablement, district nursing, community beds and equipment services. Further work is being undertaken to develop trusted assessors for nursing homes. This will include a pilot into the use of telemedicine to support remote assessment of patients by care homes.

Change 7 Focus on choice. The LIDS Team are responsible for ensuring a focus on choice. The LIDS Team undertakes a weekly review of all patients that are in the process of choosing a care home. We have a robust escalation process in place to support those patients where delays are beyond that which would be reasonably expected. The LIDS Team includes resource from Age UK Leeds that supports patients to find a care home

Change 8 Enhancing health in care homes. Leeds CCGs and the LA have a number of schemes in place to support care homes. Work is currently being undertaken to review provision and identify good practice across the three CCGs with the aim of developing a single model for all care homes. The Leeds health system are looking at

a range of initiatives, including increasing access to IT (telecare) to support care homes in future. We are part of the West Yorkshire Care homes

8. Overview of funding contributions

Funding contributions into the BCF have been agreed and confirmed. For 2017/18 these are:

- £51.2m minimum CCG contribution,
- £6.2m Disabled Facilities Grant,
- £16.2m both elements of the improved Better Care funding in line with all directives.

In addition the local Authority has included additional contributions pertinent to two specific schemes (Leeds Community Equipment Service, and South Leeds Independence Centre).

The CCG contribution will be used in part to fund:

- Care Act duties £1.9m
- Reablement £4.5m
- Carer's Breaks £2.1m

9. Programme Governance

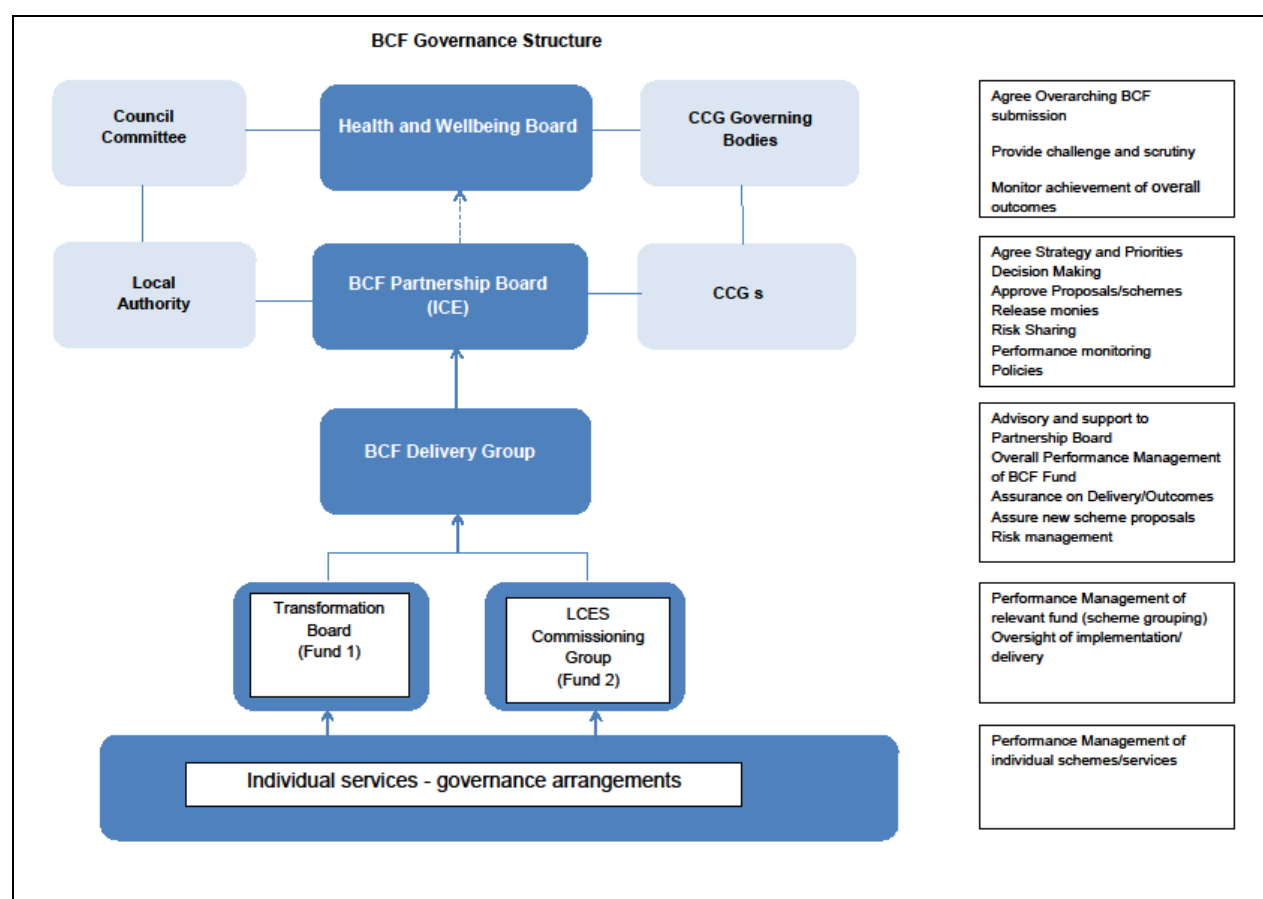
A joint review of the governance arrangements across the health and social care partner organisations during 2016/17 has resulted in the creation of the Leeds Health and Care Partnership Executive Group. Members include the Chief Executive of Leeds City Council, Accountable Officers from the Leeds CCGs, the Chief Executives from health providers, the Directors of Adult Social Services and Children's Services and the Director of Public Health. This reflects the commitment in Leeds to use shared resources – the 'Leeds pound' and represents the next step towards working as one health and care system for the benefit of everyone in Leeds.

The aim of the Leeds Plan 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. To help facilitate this, an Integrated Care Delivery Board is to be established for the city of Leeds. Its members will include representation from all three clinical commissioning groups in Leeds, Adult Social Care, Public Health Services and Primary Care.

The BCF will continue to be informed by the Leeds Plan, the Leeds CCGs' operational plans and the local A&E action plan in 2017/19. In particular the BCF will enable the

sustainability of those schemes that will help reduce NEAs, maintain the reductions achieved in respect of Delayed Transfers of Care (DTOCs) and extend the work we have done to integrate health and social care.

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



. The BCF 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 of delivery of the BCF plan.

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.

The BCF Partnership Board has been merged into the CCGs' and Council's Integrated Commissioning Executive (ICE), as they have the same membership. The Terms of Reference for ICE are attached as a supporting document, section 4 part 6 being specifically about responsibilities for the BCF. ICE is responsible for agreeing strategies and priorities and making decisions on spend within the BCF. BCF is a standing agenda item at ICE monthly meetings.

The risk sharing agreement as part of the BCF Terms of Reference (provided with the 2016/17 BCF Plan) remains in place and will be reviewed to ensure its consistency with this Plan.

10. Assessment of Risk and Risk Management

As can be seen from the Governance arrangements, risk management of the BCF Plan is addressed at multiple levels, with risk being monitored and reviewed, as appropriate by:

- Integrated Commissioning Executive
- System Resilience Assurance Board
- A&E Plan Board
- LTHT Executive Board
- BCF Partnership Board and
- BCF Delivery Group

Any new schemes are supported by a business case which has to be signed off by the Partnership Group following assurance at the Delivery Group level.

The current risk log for the Delivery Group is below:

Risk	Likelihood <i>(scale of 1-5 with 1 being very unlikely and 5 being very likely)</i>	Potential impact <i>scale of 1-5 with 1 being a small impact and 5 being a major impact</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
Funding streams are not long enough to allow delivery of the initiatives and mainstreaming of successful schemes	3	4	12	• Active performance management of Schemes to be undertaken by the BCF Delivery Group • Review of schemes/initiatives prior to year2 of the plan to rebalance if required. • CCGs to monitor to assess budget impact for year3 onwards. • Owner: BCF Delivery Group
Workforce issues – recruitment and retention of staff, has a negative impact on delivery of services	5	5	25	• Workstream within the Leeds Plan • Monitored by BCF Delivery Group? • Subject to frequent review • Owner: Accountable officers and BCF Partnership Board.

Growth in demand for services over and above that expected and planned for	2	5	10	- Schemes monitored by the BCF Delivery Group - Review of schemes/initiatives prior to year2 of the plan to rebalance if required. Owner: System Resilience group
Schemes geared towards reducing Non Elective Admissions do not have the level of impact that is expected	2	4	8	- Schemes monitored by the BCF Delivery group. - Appropriate action will be taken to address any schemes not meeting targets. Owner: Accountable officers and BCF Partnership Board.
Failure to achieve NEA targets	3	4	12	- CCGs are confident in the target, based on local demographics - The BCF Plan looks to address NEAs - Close monitoring of the target by the System Resilience Group - The financial contingency that has been identified and set aside. Owner: Accountable officers, BCF Partnership Board and LTHT executive board
Meeting the DTOC target	2	3	6	DTOC Plan and strategy for sustained improvement Owner: System Resilience group
Mainstreaming schemes into the wider transformation programme	2	3	6	Schemes not funded by BCF in 2016/17 have been placed on the CCG operational planning process for 2016/17 Owner: Integrated Commissioning Executive
Use of the Leeds £ could have an adverse impact on provider stability and/or	3	3	9	- Close monitoring of the effect of schemes and initiatives on the Provider market. - engagement in scheme delivery - provider stability - system capacity & capability Owner :BCF Partnership Board
Workforce resilience in the face of a pandemic/crisis	4	2	8	- Each partner has their own business continuity plan in place - Subject to frequent review - Escalation paths in place. Owner: Accountable officers and BCF Partnership Board.

11. National Metrics

The CCGs have submitted operational plans that assume a growth in NEA of 2.4%. This is in line with national expectation on growth. The CCG plans do not include anticipated impact of the BCF schemes as they are based on historic growth as was required by NHS England as part of planning process

There are a number of initiatives planned that may reduce activity growth below that expected e.g. increased admission avoidance through frailty unit.

As stated earlier in this document Leeds Non Elective Activity and historic growth patterns are somewhat hard to measure due to coding changes implemented by our main provider in recent years. We do now believe that the full impact of coding changes should be reflected in 2016/17 activity figures and therefore enable us to compare like with like in the current year.

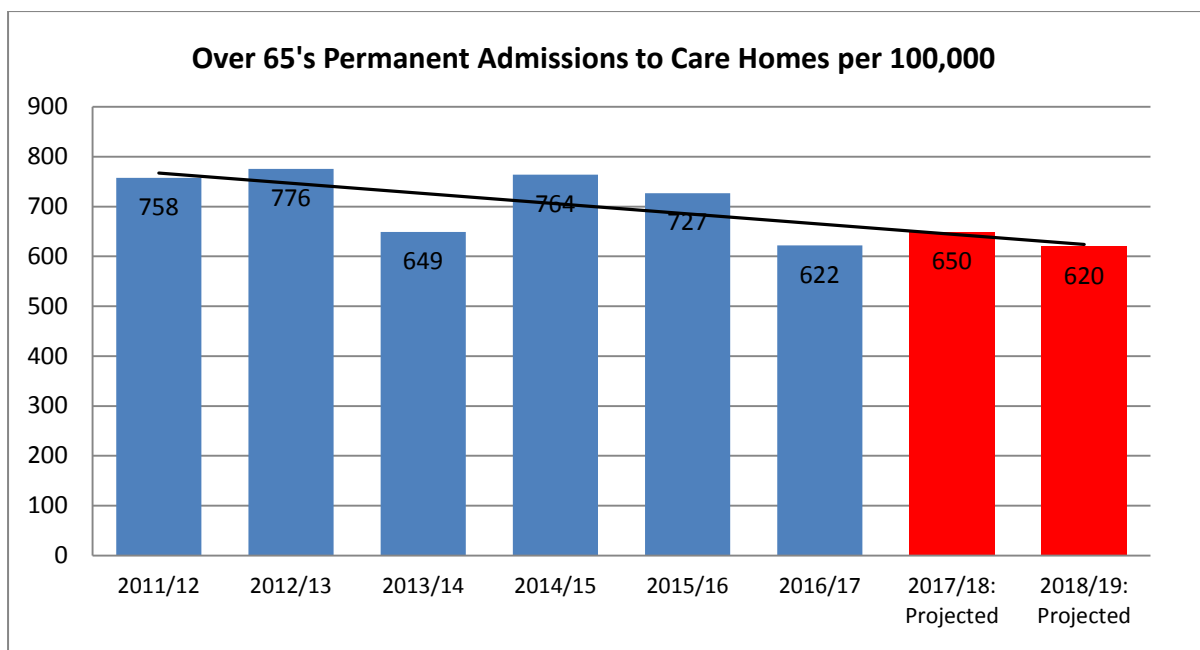
The CCGs financial position is not dependent upon on any further reduction of growth through BCF to achieve a balanced financial position. However The CCGs are holding a contingency against over performance of Non Electives. This contingency (£7million) is included in. the BCF plan.**ASCOF Measure 2A(2): Permanent Care Home Admissions for Over 65's**

The ASCOF measure looks at the number of admissions in relation to the estimated older people population for the LA. As the population estimates are changed each year by the ONS this measure does factor in and reflect estimated demographic changes.

The BCF target for 2016/17 was 750.4 admissions per 100,000 over 65 (910 actual). The outturn was well below this at 622 admissions.

Top quartile performance for 2015/16 was between 513.3 and 188 admissions per 100,000. The all England average was 628 and the comparator average 760.

The following graph includes conservative projections for 2017/18 and 2018/19 based upon recent trends and should the current direction of travel continue and self-funders continue to be excluded.



Risks and Issues

Projected trends can not anticipate the impact of any specific changes to the current context, for example, the introduction of more Community Beds or increased efforts to free hospital beds.

BCF Contribution to Target Reduction

The Community Beds scheme is expected to have a direct impact and reduce the above figure due to its focus on recovery, reablement and the aim of returning people to their own homes. The transfer to assess pathways is intended to allow people greater recuperation outside a hospital setting and both encourage and build confidence that will allow people to return to their own homes.

As documented in Section 5, the Leeds strategy is to maximise the independence of its citizens through a preventative strength-based approach to social care and linking people to the existing assets in their own communities. One intended outcome of this strategy is that the demand for care home placements will be levelled by maximising the time that people can be supported in the community. The metrics stipulated by DCLG for the iBCF returns are therefore at odds with this. Indeed, we would view a reduction in these metrics as a sign of success. We recognise that these metrics have been selected at a national level based on an assumption that all areas would view the funding of more care packages as the route to improved system flow and, in particular, reduced DTOCs. However, the funding of these packages is not an obstacle to system flow in Leeds and our investment in improving DTOC performance will focus on the agreed priorities identified through the HICM as detailed above. We are pleased therefore that you have recognised local variation such as this by inviting us to use local metrics that better reflect what we aim to achieve in Leeds whilst still

satisfying the purpose and conditions of the grant. We are therefore adopting metrics of:-

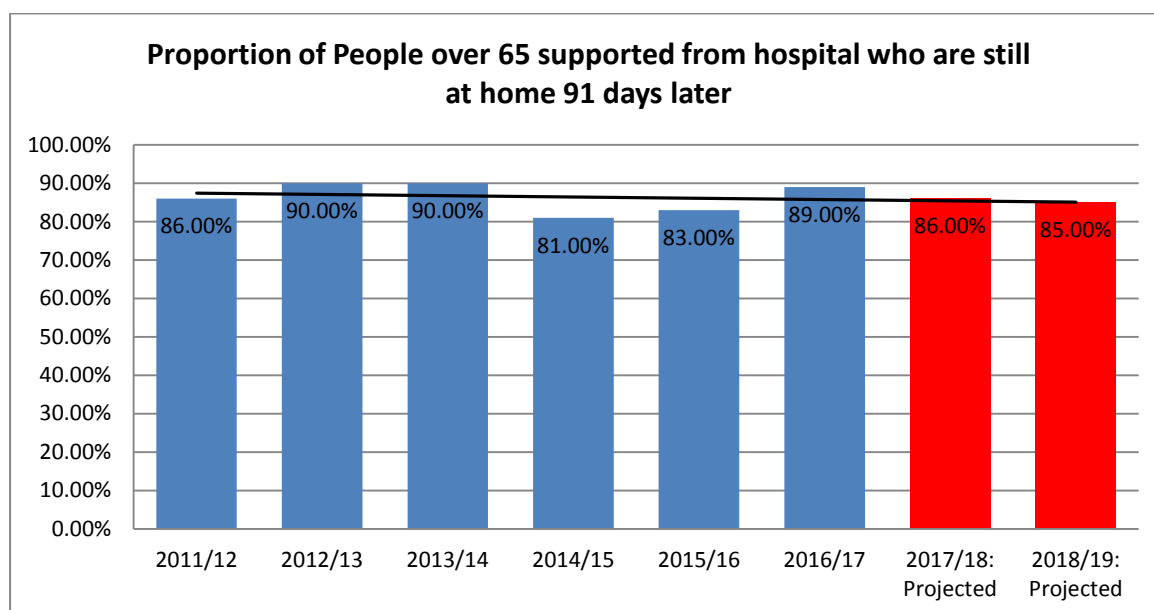
1. number of bed weeks residential/nursing care commissioned (as opposed to the number of placements in residential) and
2. number of home care hours relative to residential (non-nursing) care bed weeks

The target for 1 above is still under development. The target for 2 has been set at 2.91 for 2017/18 (actuals for 15/16 and 16/17 were 1.81 and 1.87 respectively).

ASCOF Measure 2B(1): Reablement – Proportion of people over 65 supported from hospital who are still at home 91 days following discharge

This ASCOF measure includes people who have completed reablement and a check has been undertaken by SKiLs staff 91 days following completion. In addition data is obtained through Caretrak. This includes people with social care involvement leaving hospitals that are further supported through ICT. Caretrak looks for any hospital, residential or other activity up to 91 days after discharge.

The target for the BCF 2016/17 was 92.5%. Top quartile performance for 2015/16 was between 88.6 and 100%. The all England average was 83% as was the comparator average.



Risks and Issues

It is unclear whether the Caretrak data will be available in future years due to changes in community care including access to datasets and JCM changes. Available data suggests this could have an impact upon the results of up to 8%.

Projected trends can not anticipate the impact of any specific changes to the current context, for example, the introduction of more CC beds or increased efforts to free hospital beds.

The performance target for home care reablement is being reset for 17/18 to reflect the service pathway change implemented at end of Quarter 1. Performance to be monitored through A & H DLT performance report and Budget Action Plan.

BCF Contribution

The BCF target for 2017/19 is 90%, which requires an improvement on the projected trend through the BCF schemes and initiatives.

Again the Community Beds strategy, both in increased bed numbers and new pathways aims to assist with the reablement of people, ensuring that they leave an acute setting as soon as they are able and moving to a Community setting for any necessary period of recovery, rehabilitation and reablement. The Community Beds and other Recovery Hubs can also be used as a step-up service, thus ensuring that any deteriorating conditions are addressed rapidly and before they deteriorate to the stage where acute services are required.

The new service model for home care reablement has been introduced to

1. Improve the speed at which the service picks up customers referred to it.
Under the previous model, 40% of customers the service accepted never actually started the service. The delays were related to a range of factors, from the person changing their mind about accepting the service, lack of appropriate documentation being provided from the assessor, the person not being fit to leave hospital or the person being admitted to hospital.
The new model, as described above, includes that the specific assessment and planned out comes for the service are done by the service itself, and the service will now respond to a referral (where appropriate) within four hours.
2. Introduce a full service 7 days a week 8 am to 10pm
The service can now accept new referrals and respond 7 days a week and extended hours. This includes being able to call on Occupational Therapy support 7 days a week 8am to 8pm from a new Occupational Therapy Recovery Team.
3. Widen the range of reablement interventions
The support worker role has now been extended to work with customers outside the home as part of their reablement to link them back into community activity or to support them to develop new social contacts.
4. Enable people to leave the service more smoothly at the end.
5. Along with the issue in 1 above that meant 40% of accepted referrals never actually started service, service flow has also been impaired by the slowness of moving customers out of reablement once the service and customer agreed they had reached the maximum benefit.

6. In the new model, where the person does not need any ongoing support funded through an individual care plan, the SkILs service can discharge the person without reference back to care management. They will provide advice and signposting as part of that service. Where the person does need ongoing support, eg long term home care, provided and funded through a care plan, the Social Work Service have committed to pick up that referral in 48 hours. The aim is to get the statement of people's needs (known as an Individual Service Agreement – ISA) to Care Communications Centre as quickly as possible so that an appropriate long term provider can be identified.
7. The new model was introduced with particular reference to joint working with the Leeds Integrated Discharge Service (LIDS) who have been agreed as Trusted Assessors to refer directly to the service. The joint working and relationships between SkILs and LIDS has been a very positive aspect of the introduction of the new model and is enabling us, we all think, to have a real impact on flow out of LTHT.

The Leeds Health and Care Systems have reviewed and agreed a trajectory that will result of over 25% of bed days associated with DTOCS. This equates to a reduction of an average of 83 to 59 DTOCs per day. This will be achieved through a reduction of 13 DTOCs that are waiting for a response from Health services and 11 per day related to social care/local authority.

We have undertaken an analysis of the DTOCs to understand the reasons for delays across all providers that admit Leeds patients. The table outlines the provider breakdown of the Leeds Delays

Organisation	Leeds Total	Split	
		LA	Health
LTHT	59	8	51
LYPF	11	10	1
Others	13	6	7
Total Average Winter	83	24	59
Targets	59	13	46
Reductions	24	11	13

The table above shows that 70% of the Leeds DTOCs are in Leeds Teaching Hospital (LTHT). Our analysis of the DTOCS in LTHT indicate that on average of the 59, 51 will be attributable to health and 8 will be attributable to LA.. This suggests that whilst health will need to focus largely on LTHT to reduce its DTOCs the LA will need to place a greater emphasis on other providers. This creates a significant challenge as it will

require work on a number of fronts. The table below outlines delays in LTHT as % in each category

Category	National	Leeds
Awaiting Completion of Assessment	18%	17%
Awaiting further non acute NHS Care	18%	12%
Awaiting Care Home Package	17%	4%
Awaiting Nursing Home Placement or availability	13%	3%
Awaiting Residential Home Placement or availability	11%	0%
Patient or Family Choice	12%	50%
Awaiting Public Funding	4%	2%
Housing	3%	4%
Awaiting Community Equipment or Adaptions	2%	6%
Disputes	1%	2%
* If we include Mental Health as all Non Choice overall % in Choice would be 43%		
* Improving Choice wouldn't contribute to LA targets		

For health the key focus will be on LTHT with a focus on the following

- a) Through the use of increased capacity in the Integrated Discharge Service to eliminate delays associated with assessment
- b) Increasing flow into transfer assess beds (new CIC service) to reduce number of patients waiting for NHS non Acute Care
- c) Improving processes to reduce time patients are taking to choose care homes. This will include enhancing support to patients through use of Age UK to act as 'estate agent' for patient when choosing homes along with increasing focus on working with patients and families to ensure minimum stays for those patients who are struggling to secure a placement in their preferred home.
- d) Consideration of improving capacity for hard to place patients that are suffering from dementia and as such are being refused placements by care homes

For Adult Social Care the focus will be wider including

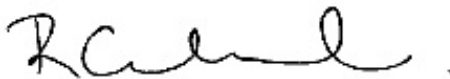
- a) Increased Hospital Social Work capacity at LTHT to minimise assessment delays
- b) Increasing use of re-ablement and transfer to assess beds to reduce delays for patients waiting in an acute hospital bed for home care package or care home placement. These patients will now be managed in sub-acute settings
- c) Review of approach to delays in Mental Health Trust. This may include improving time taken to place patients for dementia care and into supported housing.

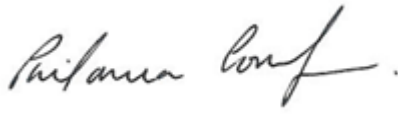
- d) Review of delays in Harrogate and Mid Yorks to reduce overall time taken to support discharge. This may include increased use of discharge to assess capacity

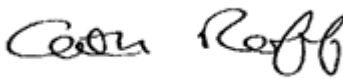
12. Approval and sign off

Provide confirmation of who has signed up to the BCF plan

Provide the date of Health and Wellbeing agreement (for the second submission of plan)

Signed on behalf of the Health and Wellbeing Board	Leeds Health and Wellbeing Board
	
By	Cllr Charlwood
Position	Chair of Health and Wellbeing Board
Date	11 September 2017

Signed on behalf of the Clinical Commissioning Groups	Leeds South and East CCG
	
By	Philomena Corrigan
Position	Chief Executive
Date	11 September 2017

Signed on behalf of the Council	Leeds City Council
	
By:	Cath Roff
Position	Director of Adults and Health
Date	11 September 2017

Reference documents

- [Leeds Health and Wellbeing Strategy](#)
- [West Yorkshire Sustainability and Transformation Plan](#)
- [Leeds Housing Strategy 2016 - 2021](#)
- [Leeds Market Position Statement 2015-18 \(revised June 2017\)](#)
- [A3 Version of the Leeds Health and Care Plan on a Page](#)
- [Draft Leeds Health and Care Plan](#)
- [Delivering the forward view: NHS Planning guidance 2016 - 2021](#)

Appendices: Supporting Documents

- Appendix 1a: Schemes supported by BCF Monies (Any new or amended schemes are highlighted in yellow)
- Appendix 1b: Schemes supported by iBCF Monies
- Appendix 1c: Integrated Commissioning Executive (ICE) Terms of Reference

Appendix 1a

2017/18 Better Care Fund (starting position)

Pooled Fund	Scheme	Services	Total Value £	Partnership Contributions			
				South & East	West	North	Leeds City Council
Page 231 Fund 1: CCG Hosted Services	Mental Health (Leeds North CCG)	Advocacy stat	142,000	52,838	55,479	33,682	0
		Alzheimers	112,000	41,675	43,758	26,566	0
		Community Links	2,582,459	960,933	1,008,967	612,559	0
		Dementia Advocacy support	57,296	21,320	22,386	13,591	0
		Dementia post	36,240	13,485	14,159	8,596	0
		Leeds Involving people	49,344	18,361	19,279	11,704	0
		Leeds Mind befriending	30,000	11,163	11,721	7,116	0
		Leeds Mind employment service	626,000	232,935	244,578	148,487	0
		Leeds survivor led crisis service	257,382	95,772	100,559	61,051	0
		Making space	79,000	29,396	30,865	18,739	0
		MH carers (LPFT)	72,000	26,791	28,130	17,078	0
		Touchstone	262,795	97,786	102,674	62,335	0
		Scheme Subtotal	4,306,516				
	CCG Community & Third Sector Services	CHC respite	278,126	103,296	98,039	76,791	0
		Community Matrons (LCH)	2,600,000	935,480	1,046,500	618,020	0
		Geriatricians (additional) (LCH)	195,000	70,161	78,488	46,352	0
		HALP (LCH)	182,661	65,721	73,521	43,419	0
		HALP Primary Care (Bevan Healthcare)	57,339	20631	23079	13629	0
		LD Respite	1,300,000	483,730	507,910	308,360	0
		Leeds bereavement care (CRUSE)	58,000	21,582	22,661	13,758	0
		Leeds bereavement forum	39,000	14,512	15,237	9,251	0
		Leeds Society for Deaf & Blind	70,000	25,186	28,175	16,639	0
		Stroke Association	76,000	27,345	30,590	18,065	0
		William Merritt	172,000	61,886	69,230	40,884	0
		Balance from DIAL Decommissioning	22,478	8,088	9,047	5,343	0
		Previous Balance (minus Carers Bereavement & ECLO)	13,380	4,814	5,385	3,180	0
		Scheme Subtotal	5,063,984				
	Community Beds	Bed Bureau (LCH)	50,000	17,990	20,125	11,885	0
		CIC beds(excluding Reablement)	2,689,285	967,605	1082437	639,243	0
		CIC beds Medical cover	126,170	45,396	50,783	29,991	0
		12 CIC beds	470,000	169,106	189,175	111,719	0
		ICT therapies support for 12 beds (LCH)	180,000	64,764	72,450	42,786	0
		Reablement-Richmond House	632,000	227,394	254,380	150,226	0
		V Ward/CICU (LCH)	2,000,000	719,600	805,000	475,400	0
		Scheme Subtotal	6,147,455				
	Enhancing Primary Care Services	Various	2,141,204	734,127	881,731	525,345	0

	Admission Avoidance - Marginal Tariff/NEL	Various	2,800,000	1,007,440	1,127,000	665,560	0
	Information Technology	Various	467,050	168,045	187,988	111,018	0
Fund 1 Total Value:			£20,926,209				

Pooled Fund	Scheme	Services	Total Value £	Partnership Contributions			
				South & East	West	North	Leeds City Council
Page 43 Fund 2: Council Hosted Services	South Leeds Independence Centre	SLIC	2,070,715	514,771	575,863	340,081	640,000
		SLIC pharmacy	10,500	3,778	4,226	2,496	0
		SLIC Medical cover	145,000	52,171	58,363	34,467	0
		Scheme Subtotal	2,226,215				
	Leeds Community Equipment Service	LCES (minus CHC Equipment)	4,385,541	676,978	757,320	447,243	2,504,000
		Continuing Healthcare Equipment (shift to fund 1?)	632,000	227,394	254,380	150,226	
		Scheme Subtotal	5,017,541				
	ASC Community & Third Sector Services	Advocacy consortia	37,492	13,490	15,091	8,912	0
		Age UK Leeds (formerly Age Concern in fund 1)	20,000	7,196	8,050	4,754	0
		Carer's Home respite	98,210	35,336	39,530	23,345	0
		Carers respite breaks	100,000	35,980	40,250	23,770	0
		Carers support	115,626	41,602	46,539	27,484	0
		Carers - Bereaved Carers Project	39,774	14,311	16,009	9,454	
		DIAL (17/18 Non-recurrent only)	15,000	5,397	6,038	3,566	0
		Forum Central (formerly LOPF and Volition)	85,582	31,461	33,806	20,315	
		Reablement	2,807,000	1,009,959	1,129,818	667,224	0
		Sensory Impairment Support (ECLO from Fund 1 Balance)	17,352	6,243	6,984	4,125	
		Scheme Subtotal	3,336,036				
	Central Allocations	NHS England 11/12 Leeds City Council allocation					
		Care bill	14,466,000	4,652,265	5,851,498	3,962,237	0
	Disabilities facilities grant	Various	5,630,909		0	0	5,630,909
Fund 2 Total Value:			£30,676,701				
Contingency fund			7,500,000	2,475,317	3,193,750	1,830,933	0
Total BCF Value 2016-17			59,102,910	(includes LCC contributions)			

SUPPORTED

Reference	Proposal (summary)	Intended Impact	Requested by	2017/18	2018/19	2019/20	Total
Prevention/early intervention				£	£	£	£
SB2	Further testing of Asset Based Community Development (ABCD)	Prevention/Self Care/Self Management - OP	Mick Ward	55,000	115,000	-	170,000
SB7	Sustain the CCG/Time to Shine funded 'Supporting Wellbeing and Independence for those living with Frailty service	Prevention/Self Care/Self Management - OP	Lucy Jackson	60,000	60,000	60,000	180,000
SB8	Customer Access -To fully adopt strength based social care	Prevention/Self Care/Self Management - All	David Hargreaves /Anne McMaster	42,792	42,792	-	85,584
SB12	Development of use of Local Area Coordination (LAC) support	Prevention/Self Care/Self Management -LD	Shona McFarlane	90,000	258,000	258,000	606,000
SB13	Dementia: information & skills (online information & training)	Prevention/Self Care/Self Management -OP/D	Tim Sanders	40,000	70,000	155,000	265,000
SB14	Embed Falls Prevention Programme - Make if Fall proof and PSI	Prevention/Self Care/Self Management - OP	Lucy Jackson	130,000	130,000	130,000	390,000
SB15	Time for Carers - increase the funding of grant	Carer Capacity - ALL	Ian Brooke-Mawson	75,000	75,000	75,000	225,000
Page 23 SB17	Working Carers - expand existing and on-going work at Carers 'Leeds Working Carers Project'	Carer Capacity - ALL	Ian Brooke-Mawson	25,000	25,000	25,000	75,000
SB22	Better Conversations for Health and well being a training programme and culture change across Leeds	Prevention/Self Care/Self Management - All	Lucy Jackson	100,000	100,000	100,000	300,000
SB26	To ensure the sustainability of social care Lunch Club provision from 2018/19	Prevention/Self Care/Self Management - OP	Lucy Jackson /Richard Porter	-	166,500	166,500	333,000
SB28	Green Gym (TCV) -links mental and physical health which has become a priority for the city as it is highlighted in the 5 Year Forward View for Mental Health	Prevention/Self Care/Self Management - MH	Sinead Cregan	142,879	181,854	167,359	492,092
SB30	Increase capacity of Neighbourhood Networks	Prevention/Self Care/Self Management - OP	Mick Ward	-	282,000	564,000	846,000
SB34	Ideas that Change Lives (ITCL) Investment fund	Prevention/Self Care/Self Management - All	Mick Ward	25,000	25,000	-	50,000
SB37	To create volunteer driver posts at Assisted Living Leeds to collect small items of equipment	Prevention/Self Care/Self Management - OP	Katie Cunningham	25,000	10,000	5,000	40,000
SB39	Learning resource in recovery hubs (dementia/MH)	Prevention/Self Care/Self Management - OP/D	Katie Cunningham /Dianne Colley	80,000	20,000	20,000	120,000
SB41	To create a 2 year fixed term post of Business Development Manager for Assistive Technology.	Prevention/Self Care/Self Management - OP	Liz Ward	28,692	54,885	54,885	138,462
SB44	Positive Behaviour service	Prevention/Self Care/Self Management - LD	Janet Wright	250,000	250,000	250,000	750,000
SB61	Falls (LCH)	Prevention/Self Care/Self Management -OP	Megan Rowlands	76,391	155,975	159,243	391,609
Reducing pressure on the NHS				1,245,754	2,022,006	2,189,987	5,457,747
SB3	To increase flow through SKILS reablement service	DToc/Return within 91 days - OP	Liz Ward /Julie Bootle	140,406	270,812	270,812	682,030

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Reference	Proposal (summary)	Intended Impact	Requested by	2017/18	2018/19	2019/20	Total
SB21	To establish the ‘Leeds Malnutrition Prevention Programme’ targeted at those over age 65.	NEA/LoS/DToC	Richard Porter	-	51,000	-	51,000
SB24	To ensure the sustainability of the Health Partnerships Team after 2018/19	Integration & Partnership Working	Lynne Hellewell	-	153,900	153,900	307,800
SB25	Development of sustainabl peer support networks for people with long term conditions	Prevention/Self Care/Self Management - OP (Health)	Lucy Jackson	70,000	70,000	70,000	210,000
SB31	Equipment service	DToC - OP	Liz Ward	410,000	350,000	350,000	1,110,000
SB36	Telecare Room package for the recovery bed bases (CAPITAL?)	DToC/Return within 91 days - OP	Katie Cunningham	195,000	-	-	195,000
SB49	Yorkshire Ambulance Service Practioners scheme		Phil Corrigan	250,000	250,000	250,000	750,000
SB50	Frailty Assessment Unit		Debra Taylor Tate	350,000	350,000	350,000	1,050,000
SB52	Hospital to Home Service	DToC - OP	John Tatton	420,000	210,000	105,000	735,000
SB54	Staffing resilience for addressing key Health pressure points	DToC - OP	Julie Bootle	109,437	109,437	109,437	328,311
SB55	Business Support to facilitate smoother and quicker discharge	DToC - OP	Julie Bootle	54,171	54,171	54,171	162,513
SB58	Respiratory Virtual Ward	DToC - OP	Allison Gummerson	273,467	558,415	-	831,882
SB66	Rapid Response	NEA/DToC	Julie Bootle	66,567	66,567	66,567	199,701
SB64	Trusted Assessor (lgi)		Sajid Azeb	100,000	200,000	200,000	500,000
SB65	Trusted Assessor (sjuh)		Sajid Azeb	100,000	200,000	200,000	500,000
• Sustainability of the care market				2,539,048	2,894,302	2,179,887	7,613,237
SB23	To ensure the sustainability of alcohol and drug social care provision after 2018/19	Prevention/Self Care/Self Management - D&A	Lynne Hellewell	-	365,120	365,120	730,240
SB35	A&H - Change Capacity	Efficient Business Processes (incl. payments)	Steve Hume	100,000	100,000	100,000	300,000
				100,000	465,120	465,120	1,030,240
• Leeds Health and Care Plan				666,667	666,667	666,666	2,000,000
TOTAL				4,551,469	6,048,095	5,501,660	16,101,224
Slippage/reinvestment							- 2,601,224
				Amount available for schemes			13,500,000



Leeds Health and Care Integrated Commissioning Executive (ICE)

Terms of Reference

Version: V1.0 | August 2017





1.0 Name

Full name: Leeds Health and Care Integrated Commissioning Executive
Accepted abbreviations: ICE

2.0 Context

The **Leeds Health & Wellbeing Strategy 2016-2021** aims to make Leeds a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest. That's why, as leaders of statutory organisations across the city, we have come together to create 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 children, young people and adults across the city; the patients and carers of today and tomorrow.

We know that we will only meet the needs of individuals and our population if health and social care workers and their organisations work together in partnership.

We understand that the needs of patients and citizens are changing; the way in which people want to receive care is changing, and that people expect more flexible approaches that fit in with their lives and families.

Front line staff, leaders and managers across organisations are coming together in many ways. We are working closely with the voluntary, faith and charitable organisations, universities and investors to act as one; as if we were a virtual 'single organisation' to improve the health and wellbeing of the people who live or use services in Leeds.

To do this, the Chief Executives and Accountable Officers of the statutory health and care organisations based within Leeds, have agreed to work together in four ways:

1. Work with people and families to enable them to take more control of their own health and care needs.
2. Provide high quality services in the right place, backed by excellent research, innovation and technology - including more support at home and in the community, and using hospitals for specialised care.
3. Remove barriers to make team working across organisations and professional groups the norm so that people receive seamless integrated support.
4. 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.

We know that through working together and seeking out opportunities to integrate our commissioning we will help to accomplish our individual organisational and collective goals and deliver greater outcomes for the people of Leeds. The NHS Five Year Forward View has suggested a sustainable strategy should address three clear areas of improvement on which to focus our efforts:

- **The health and wellbeing gap:** if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.



- **The care and quality gap:** unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- **The funding and efficiency gap:** if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

The **Leeds Health and Care Plan** applies this in a plan for all ages that will:

- Protect the vulnerable and reduce inequalities
- Improve quality and inconsistency
- Build a sustainable system within the reduced resources available

ICE will be cognoscente of the need for integrated provision and to this end when considering decisions will ensure our hospitals, community health and care service providers, GPs, local authority and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that will

- Change the conversation around health and care and have citizens at the centre of all decisions
- Build on the strengths in ourselves, our families and our community; working with people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong
- Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens
- Use neighbourhoods as a starting point to further integrate our health, social care and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis
- Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do
- Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire

When working together in partnership, we have agreed a set of principles to help guide our behaviours and values.

Principles of our approach		
We put people first: We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce.	We deliver: We prioritise actions over words to further enhance Leeds' track record of delivering positive innovation in local public services. Every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.	We are team Leeds: We work as if we are one organisation, taking collective responsibility for and never undermining what is agreed. Difficult issues are put on the table, with a high support, high challenge attitude to personal and organisational relationships.



All of this will help to ensure that we contributing to achieving the five outcomes set out in the Leeds Health and Wellbeing Strategy 2016-2021:

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

Progress will be measured at citywide level, and individual organisations will develop any necessary indicators to make sure we are all playing our part.

3.0 Assumptions

The four statutory delivery organisations that make up ICE 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

ICE will support the Leeds Health and Care Plan to 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
- Ensuring that throughout we work with our citizens and workforce (not doing things to them or for them), 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.

ICE will consider recommendations on which services offer least value in terms of outcomes to the Leeds £.

4.0 Specific functions undertaken by the group

ICE will explore and negotiate opportunities for commissioning of health and social care services in Leeds in a more joined-up manner. This will enable a regular dialogue between the NHS Leeds CCG health commissioners, Leeds City Council social care commissioners and the third sector to enable effective collaboration and decision making which is subject to individual governance arrangements for the NHS Leeds CCGs and Leeds City Council. This will improve health and care services and the health and wellbeing of children, young people, adults and communities in Leeds.

Furthermore, by enabling integration and unblocking system-wide barriers to integration, ICE will ensure the implementation of the Leeds Health and Wellbeing Board's long term strategy for the city and co-ordinate the partnership's commissioning actions to achieve the priorities in the Leeds Health and Wellbeing Strategy 2016-2021.



1. Supporting the delivery of the Leeds Health & Wellbeing Strategy

- Using the 5 outcomes and 12 priorities within the Strategy to set the direction and focus of discussions, giving a strategic steer to any financial and governance discussions around the integration of commissioning.
- Ensure that ICE supports to the work of the Leeds Health and Wellbeing Board and the Leeds Health and Care Partnership Executive Group (PEG).

2. Integrated Commissioning Strategy

- Develop and have oversight of an Integrated Commissioning Strategy and collective commissioning integrated resources with a holistic approach of its implications and decision making across the whole health and social care system.
- Set system priorities for shared challenges.
- Maximise the impact of 'Leeds assets' and the value of every 'Leeds Pound' spent on improving health and social care for the population in the context of reducing resources across the health and social care system and where appropriate achieve this by jointly exploring re-prioritisation of resources across the system.
- Make specific proposals for integrated commissioning of services between health, social care, children's services and public health, using pooled or aligned budgets in line with the Health and Social Care Act 2012.
- Support the health and care system by considering commissioning decisions which will help to establish a population based approach to commissioning and provision of outcomes for an initial, accelerator population segment whilst simultaneously continuing to deliver priority pathways as part of on-going Leeds Health and Care Plan work.
- Assess, shape and respond to the commissioning landscape at a local and regional level.
- Identify opportunities for collaborative and integrated commissioning.
- Identify and develop opportunities for shared posts.
- Identify opportunities for greater efficiency and effectiveness of commissioning and promote a holistic approach to commissioning processes.
- Share and discussing the commissioning plans of all partners.
- Monitor and manage the performance of jointly commissioned work.
- Ensure proposals have had active engagement with patients, service users and the third sector through appropriate standing groups to inform process and reflect the service user's and carer voice's and experience into the planning, delivery and evaluation of health and social care services.

3. Commissioning Delivery

- Identify innovative approaches to resource allocation and proposing new approaches of delivery.
- Identify and develop opportunities to integrate the commissioning workforce.
- Discuss effective and efficient use of commissioning support functions.
- Measuring the impact and implications of commissioning decisions for the health and care system and tracking and receiving assurances that delivery has occurred.

4. Payments and Incentives

- Design and test a framework for system wide commissioning.
- This involves consideration of new contractual models to incentivise outcomes we want.



5. Innovation and Enterprise

- Liaise with academic research and innovation (through Academic Health Partnership) where appropriate to ensure mutual coordination and system support for commissioning strategy in relation to the appraisal and consideration of pilots, and review of high-profile bids for grant funding that bring innovation and resources into Leeds.
- Share the learning from the Leeds health and social care system and draw on innovation at a regional, national and international level.
- Identify how Leeds can use its unique health and care infrastructure and joint strategies to unblock any issues around integrated commissioning.

6. Better Care Fund (BCF)

- Oversee the BCF partnership agreement between the NHS Leeds CCGs and Leeds City Council and to monitor the BCF including reviewing the operation of the partnership agreement and risks sharing arrangements.
- Act as a forum for reviewing and considering plans and proposals for BCF funding and promoting the agenda on integration.
- Make recommendations to the Leeds Health and Wellbeing Board in terms of the strategic planning for the Better Care Fund.
- Review quarterly and annual returns, which will be submitted to the Leeds Health and Wellbeing Board and circulated to NHS Leeds CCGs and Leeds City Council Executive Board as appropriate.
- Provide strategic direction, approve, monitor the implementation and performance of individual schemes/services on an exception basis.
- Approve the terms of reference of the BCF Delivery Group as a sub group of ICE, which will provide advice and support to ICE in relation to BCF.

4.0 Budget

Currently a budget is not allocated to support the operations of the group and any work is done in kind by partners.

4.1 Considerations for the future

Proposals are being developed for a citywide team to support the work of the partnership. Following these recommendations, consideration will be given for a specific budget to be allocated by partners on a fair shares basis to support this group.

5.0 Membership

ICE will be jointly chaired by the NHS Leeds CCG Chief Executive Officer and the Director of Adult and Health.

A key feature of the ICE is that the role of members is not to represent the needs of their host organisations, but to represent the best interests of the people of Leeds, thinking city first, organisation second.



5.1 Core Membership

Core membership will consist of:

Organisation	Role
NHS Leeds CCGs Partnership	Chief Executive Officer (Co-Chair of ICE)
NHS Leeds CCGs Partnership	Chief Officer for System Integration
NHS Leeds CCGs Partnership	Clinical Chair
NHS Leeds CCGs Partnership	Clinical Chair
NHS Leeds CCGs Partnership	Director of Commissioning
NHS Leeds CCGs Partnership	Director of Finance
NHS Leeds CCGs Partnership	Deputy Director of Commissioning (Community Services)
Leeds City Council	Director of Adults and Health (Co-Chair of ICE)
Leeds City Council	Director of Children & Families
Leeds City Council	Chief Officer Partnerships, Children & Families
Leeds City Council	Director of Public Health
NHS Leeds CCGs Partnership and Leeds City Council	Deputy Director, Integrated Commissioning, Adults and Health and NHS Leeds CCGs
Yorkshire and the Humber, NHS England	Director of Commissioning Operations

5.2 In attendance where appropriate

Organisation	Role
City-wide	Chief Officer Health Partnerships
City-wide	Executive Lead for Lead Health and Care Plan
City-wide	Finance Lead for Leeds Health and Care Plan
Leeds City Council	Chief Officer Resources and Strategy, Adults and Health

5.3 Substitutes

All members will prioritise attendance at each meeting. Each of the key statutory commissioning functions within the city are represented by at least two representatives at ICE which in effect are acting as substitutes for each other.

Members should not be absent from two consecutive ICE meetings or not be present at less than 9 formal meetings in any 12 month period unless there are exceptional circumstances.

5.4 Special advisors

The group may request special advisors to be present for specific agenda items. These may include those representing specific commissioning functions, enabling groups, advising on policy, providing communications support etc.

Requests for special advisors to be in attendance are to be made via the Health Partnerships Team who administers the group.



6.0 Governance

6.1 Decision making, Voting and Quoracy

6.1.1 Decision making

The group draws together senior officers from the partnership and all decisions made within the group are through the authority delegated to individual members of the group from their host partner organisation and conducts its business in the spirit of partnership. Each partner retains its own statutory functions and responsibilities.

The group will provide reports to various host organisation bodies on an issues/exception basis, with no formal reporting timetable in place.

It is the responsibility of ICE's members to obtain appropriate approval within their own organisations (if required) for any decision taken at ICE.

6.1.2 Voting & Quoracy

The group will be expected to reach a consensus when agreeing matters of business. This will mean that members are expected to compromise and demonstrate the behaviours listed within the Terms of References.

Quorum for the group will be at least 50% of core members present which must include:

- Two members from Leeds City Council
- Two members from the NHS Leeds CCGs

At the discretion of the chair, where a decision/vote impacts an organisation whose representative member is not present at the meeting a nominated representative will seek agreement outside of the meeting or the decision/vote is deferred to a future meeting.

6.2 Relationship with other Boards/Groups

The ICE will provide reports to various host organisation bodies and partnership boards/groups on an issues/exception basis, with no formal reporting timetable in place. It will have a close working relationship with a number of key bodies including:

- Leeds Health and Wellbeing Board
- Children & Families Trust Board (CFTB)
- Children's Joint Commissioning Group (sub group of ICE and CFTB)
- BCF Delivery Group (sub group of ICE)
- Leeds Health and Care Partnership Executive Group (PEG)
- Clinical Senate
- System Resilience Assurance Board (SRAB)
- Accountable Care Development Board
- Population Health Management Group
- Leeds Academic Health Partnership (LAHP)
- Joint Adult Community Commissioning Group
- LD Board (including Transforming Care Programme)
- Mental Health Partnership
- Dementia Board



- Leeds Plan Delivery Group
- Leeds Health Commissioning and System Integration Board
- LCC Corporate Strategic Commissioning Group
- LCC Executive Board

It is anticipated that the above named boards and groups will continue to drive innovation and service change through wider partnership engagement including service providers. ICE will make recommendations for investment and disinvestment across the partnership based on the work and strategies of the related bodies.

6.3 Considerations for the future

As the group develops, consideration will be given to more formal governance/decision making models for example, Committee in Common.

7.0 Meetings

7.1 Frequency

Group will aim to formally meet at least once a month. There may be occasions where this is not possible however, as much notice as possible will be given to any changes in dates/times.

Additional meetings may be arranged if required.

7.2 Duration

Each formal meeting is expected to last 3 hours, promptly starting at 14:00 where possible. This will consist of a focus on strategic commissioning related items between 14:00-16:00 and Better Care Fund specific related items between 16:00-17:00 where appropriate.

Meetings may be extended in duration if appropriate at the discretion of the Chairs.

7.3 Bringing items

A forward plan for the group will be developed by the group supported by the Health Partnerships Team. This will be reviewed and updated in each meeting.

Additional items can be proposed by Core Members. In addition, a referral can be made from the Leeds Health and Wellbeing Board or the Leeds Health and Care Partnership Executive Group.

A request should be made to the Health Partnerships Team who will collate items into a draft agenda which will be discussed and agreed with the Chairs.

The following information must be provided for any items requested:

1. Title for the item
2. Primary group sponsor for the item
3. Author(s) for the item
4. Reason for coming to the group and expected outcome
5. Estimation of minimum amount of time required for the item



6. Which group meeting the item is requested to come to and an assessment of the criticality of the item coming (i.e. this will assist with determining which items must be on the agenda for a specific meeting if there are too many items).

7.4 Structure of meetings

All formal meetings will have an agenda.

Items will be accompanied with a supporting paper and as a minimum an item cover sheet will be completed for any items that require a decision/agreement by the group.

The following items will be standard on all formal agenda meetings:

- Welcome
- Apologies
- Declaration of any conflicts of interest with any of the items that are being discussed as part of the agenda will be raised and noted
- Update on actions from previous meetings
- Additional items as per agenda
- Hot Topics
- Review of forward plan

8.0 Standards

8.1 Declarations of interest

All group members must complete a declaration of interests form.

Declarations of interest may be published and reviewed as a standing item on all meeting agendas. Attendees who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chairs of the meeting will decide the course of action required, which may include exclusion from participation in the discussion.

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

8.2 Behaviours and practice all members will demonstrate

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds with a commitment to ensuring everything the group does is outcome based, evidence informed and patient/service user informed.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- Actively work to remove barriers that prevent team working.
- Hold each other to account.
- Be clear in language used to reduce any confusion between group members.



- Seek clarity from other group members if unsure of terminology/language used.
- Offer constructive challenge to improve service delivery and ensure financial balance.
- Openness and transparency in decision making, being explicit of when not agreeing/supporting a decision.
- Stick to decisions that are made at the group.
- Follow through on actions agreed at the group.
- Meet deadlines agreed at the group.
- Prioritise group meetings and core members will aim to attend the full meeting.
- Read all papers in advance of the meeting and come prepared.
- Undertake the necessary discussions within their own organisations prior to the group meeting in order to make decisions within the meeting.

8.3 Equality

The group shall have due regard to equality in all its activities, and shall take steps to demonstrate it has consulted with communities appropriately in its decisions.

8.4 Transparency and communication of discussions and decision taken

Where appropriate the group shall produce a summary of key messages. These will then be circulated to appropriate boards/groups.

9.0 Secretariat support

The secretariat support will be provided by the Health Partnerships Team under direction of the Health Partnerships Programme Manager. This will include:

1. Being a central point of contact for the group
2. Drafting and preparing the agenda
3. Issuing the call for agenda items
4. Formulating formal paper calls on behalf of the group
5. Liaising with authors/leads to ensure that papers meet the requirements of the group
6. Ensuring group meetings are minuted
7. Maintaining an action log for the group
8. Formally requesting officers to undertake specific actions on behalf of the group
9. Advising the group as required on policy
10. Identifying and organising organisational development (OD) for the group
11. Developing a programme of work / forward plan to support the group
12. Acting as a critical friend to group to ensure that group is operating and delivering its outcomes and against the ToRs

Additionally, secretariat support can be delegated by the Chairs to undertake any other activity as deemed appropriate under authority of the group to ensure that the group fulfils its objectives and function.

10.0 Date of next review

These Terms of Reference will be reviewed at approximately every 6 months. Date of next review March 2018.

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Planning Template v.14.6b for BCF: due on 11/09/2017

Summary of Health and Well-Being Board 2017-19 Planning Template

Being Board:

Leeds

Data Submission Period:

2017-19

Summary

[<< Link to the Guidance tab](#)

2. HWB Funding Sources

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£9,076,622	£9,271,669
Total iBCF Contribution	£16,188,622	£22,049,003
Total Minimum CCG Contribution	£51,228,544	£52,201,886
Total Additional CCG Contribution	£0	£0
Total BCF pooled budget	£76,493,789	£83,522,558

Specific Funding Requirements for 2017-19

	2017/18 Response	2018/19 Response
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes
2. In areas with two tiers of local government:		
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?		
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.		
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes

3. HWB Expenditure Plan

Summary of BCF Expenditure (*)	2017/18 Expenditure	2018/19 Expenditure
Acute	£10,440,000	£10,440,000
Mental Health	£5,758,000	£5,758,000
Community Health	£20,484,333	£20,976,886
Continuing Care	£278,000	£278,000
Primary Care	£2,141,000	£2,141,000
Social Care	£37,217,911	£43,928,672
Other	£174,545	£0
Total	£76,493,789	£83,522,558

Summary of BCF Expenditure from Minimum CCG Contribution (***)	2017/18 Expenditure	2018/19 Expenditure
Acute	£10,440,000	£10,440,000
Mental Health	£5,758,000	£5,758,000
Community Health	£17,607,000	£18,472,886
Continuing Care	£278,000	£278,000
Primary Care	£2,141,000	£2,141,000
Social Care	£14,830,000	£15,112,000
Other	£174,545	£0
Total	£51,228,545	£52,201,886

→

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool ()**

	2017/18 Expenditure	2018/19 Expenditure
Mental Health	£5,758,000	£5,758,000
Community Health	£17,607,000	£18,472,886
Continuing Care	£278,000	£278,000
Primary Care	£2,141,000	£2,141,000
Social Care	£0	£0
Other	£174,545	£0
Total	£25,958,545	£26,649,886
NHS Commissioned OOH Ringfence	£14,557,699	£14,834,296

Additional NEA Reduction linked Contingency Fund

	2017/18 Fund	2018/19 Fund
NEA metric linked contingency fund held from the ringfenced local allocation for NHS OOH spend	£0	£0

BCF Expenditure on Social Care from Minimum CCG Contribution

	2016/17	2017/18	2018/19
Minimum Mandated Expenditure on Social Care from the CCG minimum		£14,827,749	£15,109,477
Planned Social Care expenditure from the CCG minimum	£14,567,000	£14,830,000	£15,112,000
Annual % Uplift Planned		1.8%	1.9%
Minimum mandated uplift % (Based on inflation)		1.79%	1.90%

4. HWB Metrics

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
Total HWB Planned Non-Elective Admissions	19,568	18,492	18,027	19,157	19,706	18,623	18,153	19,296	75,244	75,778
HWB Quarterly Additional Reduction Figure	0	0	0	0	0	0	0	0	0	0
HWB NEA Plan (after reduction)	19,568	18,492	18,027	19,157	19,706	18,623	18,153	19,296	75,244	75,778
Additional NEA reduction delivered through the BCF									£0	£0

4.2 Residential Admissions

		Planned 17/18	Planned 18/19
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	650	620

4.3 Reablement

		Planned 17/18	Planned 18/19
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	90.0%	90.0%

4.4 Delayed Transfers of Care

Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
		927	1,046	891	868	877	887	887	865

5. National Conditions

National Conditions For The BCF 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?
1) Plans to be jointly agreed	Yes	Yes
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes
4) Managing transfers of care	Yes	Yes

Footnotes

* **Summary of BCF Expenditure** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:

Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

** **Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool** is the sum of the amounts allocated to the 6 individual out of hospital 'areas of spend' that have been provided in tab 4. HWB Expenditure Plan, where;

Area of Spend = Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other (everything other than Acute)

Commissioner = CCG, NHS England or Joint (if joint we use the NHS% of the value)

Source of Funding = CCG Minimum Contribution

*****Summary of BCF Expenditure from Minimum CCG contribution** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' from the minimum CCG contribution that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:

Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

Source of Funding = CCG Minimum Contribution

Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: 1. Cover Sheet

[<< Link to the Guidance tab](#)

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Health and Well Being Board	Leeds

Completed by:	Philippa Gibbons

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Contact Number:	0113 3785067

Who signed off the report on behalf of the Health and Well Being Board:	Councillor Charlwood

Area Assurance Contact Details*	Role:	Title and Name:	E-mail:
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	Local Authority Director of Adult Social Services (or equivalent)	Cath Roth, Director of Adults and Health	cath.roth@leeds.gov.uk
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Please add further area contacts that you would wish to be included in official correspondence -->			

*Only those identified will be addressed in official correspondence

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'

Complete Template

	No. of questions answered
1. Cover	6
2. HWB Funding Sources	31
3. HWB Expenditure Plan	16
4. HWB Metrics	28
5. National Conditions	12

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Leeds

Data Submission Period:

2017-19

2. HWB Funding Sources

[<< Link to the Guidance tab](#)

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Leeds	£6,199,289	£6,767,669
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Total Minimum LA Contribution exc iBCF	£6,199,289	£6,767,669

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	Yes	Yes

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Leeds	£2,504,000	£2,504,000
Leeds	£373,333	£0
Total Local Authority Contribution	£9,076,622	£9,271,669

Comments - please use this box clarify any specific uses or sources of funding
Leeds Community Equipment Service
SLIC (7 months)

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Leeds	£16,188,622	£22,049,003
Total iBCF Contribution	£16,188,622	£22,049,003

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Leeds North CCG	£12,784,302	£13,027,203
NHS Leeds West CCG	£20,763,819	£21,158,332
NHS Leeds South and East CCG	£17,680,423	£18,016,351
Total Minimum CCG Contribution	£51,228,544	£52,201,886

Specific funding requirements for 2017-19	Response	Response	If the selected response for either year is 'No', please detail in the comments box
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?			
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.			
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 3. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:

Leeds

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc IBCF	£0	£0
CCG Minimum Contribution balance	-£1	£0
Additional CCG Contribution balance	£0	£0
IBCF	£0	£0
Running Totals	2017/18	2018/19
Planned Social Care spend from the CCG minimum	£14,830,000	£15,112,000
Ringfenced NHS Commissioned OOH spend	£25,958,545	£26,649,886

		Expenditure													
		Scheme Descriptions Link >>													
Sch eme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissione r	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
1	Reablement services	16. Other		reablement	Communit y Health		CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£4,538,000	£4,538,000	Existing
2	Community beds	11. Intermediate care services	4. Reablement/Reh abilitation services		Communit y Health		CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£5,302,000	£5,302,000	Existing
3	Supporting Carers	3. Carers services	1. Carer advice and support		Communit y Health		CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£314,000	£314,000	Existing
4	Supporting Carers	3. Carers services	1. Carer advice and support		Continuing Care		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£278,000	£278,000	Existing
5	Supporting Carers	3. Carers services	1. Carer advice and support		Mental Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,469,000	£1,469,000	Existing
6	Leeds Equipment Service	1. Assistive Technologies	4. Other	equipment services	Communit y Health		CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,373,000	£2,373,000	Existing
7	3rd Sector Prevention	16. Other			Communit y Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£444,000	£444,000	Existing
8	3rd Sector Prevention	16. Other			Mental Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£4,289,000	£4,289,000	Existing
9	Admission avoidance	16. Other			Acute		CCG			NHS Acute Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,800,000	£2,800,000	Existing
10	Community Matrons	16. Other			Communit y Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,600,000	£2,600,000	Existing
11	Homeless Accomodation Pathway Leeds(HALP)	16. Other			Communit y Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£240,000	£240,000	Existing
12	Interface Geriatricians	9. High Impact Change Model for Managing Transfer of Care	5. Seven-Day Services		Communit y Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£195,000	£195,000	Existing
13	LCES 7 day working	9. High Impact Change Model for Managing Transfer of Care	5. Seven-Day Services		Acute		CCG			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£140,000	£140,000	Existing
14	Disabled Facilities Grant	4. DFG - Adaptations			Social Care		Local Authority			Local Authority	Local Authority Contribution	Both 2017/18 and 2018/19	£6,199,289	£6,767,669	Existing
15	Social Care to benefit Health	16. Other		social care to benefit health	Social Care		Local Authority			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£12,780,000	£13,062,000	Existing
16	Contingency	16. Other		contingency	Acute		CCG			NHS Acute Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£7,500,000	£7,500,000	Existing

Selected Health and Well Being Board:

Leeds

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< [Link to Guidance tab](#)

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	-£1	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	2017/18	2018/19
Planned Social Care spend from the CCG minimum	£14,830,000	£15,112,000
Ringfenced NHS Commissioned OOH spend	£25,958,545	£26,649,886

Expenditure															
Scheme Descriptions Link >>															
Sch eme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissione r	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
17	Care Bill	16. Other		care bill	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,900,000	£1,900,000	Existing
18	Enhancing Primary Care	12. Personalised healthcare at home	3. Other	?	Primary Care		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£2,141,000	£2,141,000	Existing
19	Expand Community intermediate care beds	11. Intermediate care services	4. Reablement/Reh abilitation services		Communit y Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£230,000	£230,000	Existing
20	Expand Community intermediate care beds	11. Intermediate care services	4. Reablement/Reh abilitation services		Communit y Health		CCG			Charity / Voluntary Sector	CCG Minimum Contribution	Both 2017/18 and 2018/19	£470,000	£470,000	Existing
21	Information Technology	7. Enablers for integration	2. System IT Interoperability		Other	infrastructure	CCG			Charity / Voluntary Sector	CCG Minimum Contribution	2017/18 Only	£104,000	£0	Existing
22	Former Local Reform and Community Voices grant (IHMA & G	16. Other		former social care grants	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£150,000	£150,000	Existing
23	Invest to save to be allocated	16. Other		sum available for invest to save schemes	Other	tbc	CCG			Charity / Voluntary Sector	CCG Minimum Contribution	2017/18 Only	£70,545	£0	Existing
24	Leeds Equipment Service	1. Assistive Technologies	4. Other	overall equipment service	Communit y Health		Local Authority			Local Authority	Local Authority Contribution	Both 2017/18 and 2018/19	£2,504,000	£2,504,000	Existing
25	Reablement services	16. Other		reablement	Communit y Health		Local Authority			Local Authority	Local Authority Contribution	2017/18 Only	£373,333	£0	Existing
26	iBCF - supporting packages	16. Other		summary of schemes (appendix a)	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£9,500,000	£14,500,000	New
27	iBCF - prevention	16. Other		summary of schemes (appendix a)	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£1,245,754	£2,022,006	New
28	iBCF - reducing pressures on NHS (including frailty unit, trustee	16. Other		summary of schemes (appendix a)	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£2,539,048	£2,894,302	New
29	iBCF - sustainability of the care market	16. Other		summary of schemes (appendix a)	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£100,000	£465,120	New
30	iBCF - Leeds Health & Social Care Plan	16. Other		summary of schemes (appendix a)	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£666,667	£666,667	New
31	iBCF - committed to above areas but will slip into 18/19 & 19/20	16. Other		summary of schemes (appendix a)	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£2,137,153	£1,500,908	New
32	Expand Community bed base	11. Intermediate care services	4. Reablement/Reh abilitation services		Communit y Health		CCG			CCG	CCG Minimum Contribution	Both 2017/18 and 2018/19	£901,000	£1,766,886	New

Selected Health and Well Being Board:

Leeds

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2017-19

3. HWB Expenditure Plan

<< [Link to Guidance tab](#)

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	-£1	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	2017/18	2018/19
Planned Social Care spend from the CCG minimum	£14,830,000	£15,112,000
Ringfenced NHS Commissioned OOH spend	£25,958,545	£26,649,886

Expenditure															
Scheme Descriptions Link >>															
Sch eme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissione r	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

[Link back to the top of the sheet >>](#)

Scheme Type	Description	Sub type
1. Assistive Technologies	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	1. Telecare 2. Wellness services 3. Digital participation services 4. Other
2. Care navigation / coordination	A service to help people find their way to appropriate services and support and thus also support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. This is often as part of a multi-agency team which can be on line or use face to face care navigators for frail elderly, or dementia navigators etc. . This includes approaches like Single Point of Access (SPoA) and linking people to community assets.	1. Care coordination 2. Single Point of Access 3. Other
3. Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	1. Carer advice and support 2. Implementation of Care Act 3. Respite services 4. Other
4. DFG - Adaptations	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	
5. DFG - Other Housing	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
6. Domiciliary care at home	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	1. Dom care packages 2. Dom care workforce development 3. Other
7. Enablers for integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commisioning infrastructure includes any personnel or teams that enable joint commissioning.	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Other
8. Healthcare services to Care Homes	Improve the availability and quality of primary and community health services delivered to care home residents. Support the Care Home workers to improve the delivery of non-essential healthcare skills. This includes provider led interventions in care homes and commissioning activities eg. joint commissioning/quality assurance for residential and nursing homes.	1. Other - Mental health / wellbeing 2. Other - Physical health / wellbeing 3. Other
9. High Impact Change Model for Managing Transfer of Care	The 8 changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system.	1. Early Discharge Planning 2. Systems to Monitor Patient Flow 3. Multi-Disciplinary/Multi-Agency Discharge Teams 4. Home First/Discharge to Access 5. Seven-Day Services 6. Trusted Assessors 7. Focus on Choice 8. Enhancing Health in Care Homes 9. Other

Selected Health and Well Being Board:

Leeds

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2017-19

3. HWB Expenditure Plan

<< [Link to Guidance tab](#)

Link to Summary sheet		
Running Balances	2017/18	2018/19
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
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Ringfenced NHS Commissioned OOH spend	£25,958,545	£26,649,886

Expenditure															
Scheme Descriptions Link >>															
Sch eme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissione r	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
Page 259	10. Integrated care planning		A co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.									1. Care planning 2. Integrated care packages 3. Review teams (reviewing placements/packages) 4. Other			
	11. Intermediate care services		Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and delivered by a combination of professional groups. Services could include Step up/down, Reablement (restorative of self-care), Rapid response or crisis response including that for falls.									1. Step down 2. Step up 3. Rapid/Crisis Response 4. Reablement/Rehabilitation services 5. Other			
	12. Personalised healthcare at home		Schemes specifically designed to ensure that a person can continue to live at home through the provision of health related support at home. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term and end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in the Personalised Healthcare at Home scheme type.									1. Other - Mental health /wellbeing 2. Other - Physical health/wellbeing 3. Other			
	13. Primary prevention / Early Intervention		Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.									1. Social Prescribing 2. Other - Mental health /wellbeing 3. Other - Physical health/wellbeing 4. Other			
	14. Residential placements		Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.									1. Supported living 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Other			
	15. Wellbeing centres		Wellbeing centres provide a space to offer a range of support and activities that promote holistic wellbeing or to help people to access them elsewhere in the community or local area. They can typically be commissioned jointly and provided by the third sector.												
	16. Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.												

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:

Leeds

Data Submission Period:

2017-19

4. HWB Metrics

[<< Link to the Guidance tab](#)

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
HWB Non-Elective Admission Plan* Totals	19,568	18,492	18,027	19,157	19,706	18,623	18,153	19,296	75,244	75,778

Are you planning on any additional quarterly reductions?	No

Please only record reductions where these are over and above existing or future CCG plans. HWBs are not required to attempt to align to changing CCG plans by recording reductions.

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)										
HWB Quarterly Plan Reduction %										

Are you putting in place a local contingency fund agreement on NEA?	Yes

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£14,557,699	£14,834,296

Cost of NEA as used during 16/17***	£2,050	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***	£2,050	
Cost of NEA for 18/19 ***	£2,050	

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Total 17/18
Additional NEA reduction delivered through BCF (2017/18)	£0					£0
		Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 18/19
Additional NEA reduction delivered through BCF (2018/19)	£0					£0
HWB Plan Reduction % (2017/18)	0.00%					
HWB Plan Reduction % (2018/19)	0.00%					

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017

* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

would expect the value of the contingency fund to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: [xxx insert allocation document](#)

*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	726.5	756.4	650.5	620.1	
	Numerator	866	910	791	763	
	Denominator	119,199	120,300	121,604	123,049	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1>
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	84.8%	92.5%	90.0%	90.0%	
	Numerator	629	976	994	994	
	Denominator	742	1,055	1,104	1,104	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				Comments
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	1073.9	1308.8	1171.9	1219.6	927.2	1046.0	891.3	867.8	877.5	887.1	887.1	864.6	
	Numerator (total)	6,610	8,056	7,213	7,553	5,742	6,478	5,520	5,400	5,460	5,520	5,520	5,400	
	Denominator	615,507	615,507	615,507	619,292	619,292	619,292	619,292	622,238	622,238	622,238	622,238	624,561	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1>
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Leeds

Data Submission Period:

2017-19

5. National Conditions

[<< Link to the Guidance tab](#)

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	
4) Managing transfers of care	Yes	Yes	

Leeds Health and Wellbeing Board



Report author: Geoff Turnbull (Senior Policy and Performance Officer, Leeds City Council) & Josh Willacy (Stonewall)

Report of: Leeds LGBT+ Hub

Report to: Leeds Health and Wellbeing Board

Date: 28 September 2017

Subject: Unhealthy Attitudes – A 'one city' Approach for Leeds

Are specific geographical areas affected?	☐ Yes	☒ No
If relevant, name(s) of area(s):		
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
If relevant, access to information procedure rule number:		
Appendix number:		

Summary of main issues

The Unhealthy Attitudes Report (Appendix 1) has identified some key areas to be addressed to move the Health and Social Care sector towards being fully inclusive towards LGBT+ people:

- A need for stronger leadership
- A need for more inclusive information
- A need for more role models

Recommendations

The Health and Wellbeing Board is asked to:

1. Support the establishment of a Sub Group of the LGBT+ Hub focusing on Health and Social Care and nominate representatives from each partner organisation to attend this.
2. Task the LGBT+ Hub Sub Group on Health and Social Care with developing an action plan to deliver the recommendations of the Unhealthy Attitudes Report.
3. Task the Sub Group with identifying any additional actions that may need to be delivered to ensure Health and Social Care services are fully inclusive for LGBT+ people.
4. Task the Sub Group with consulting and engaging with the LGBT+ community as required to deliver the action plan.
5. Agree to receive regular update reports on progress in delivering the action plan.

1. Purpose of this report

- 1.1 To outline the areas of improvement needed to make the health and social care sector inclusive of LGBT+ people
- 1.2 To seek the support of the Health and Wellbeing Board in the establishment of a Sub Group to consider LGBT+ issues in the Health and Social Care sector.
- 1.3 To gain the support of the Board in nominating representatives from across the sector to the Sub Group who can develop a one city approach to consulting and engaging with the community and delivering the actions identified as needed.

2 Background information

- 2.1 Leeds City Council is a Stonewall Diversity Champion. Its consultation and engagement mechanism with the LGBT+ community is the LGBT+ Hub.
- 2.2 The Hub was re-launched 2 years ago and meets quarterly. It regularly has between 40 and 70 people at its meetings from the LGBT+ community and partner organisations and services.
- 2.3 The Hub has two main aims – to challenge Leeds City Council services and partner organisations on their due regard for LGBT+ issues in their service delivery and highlighting the diversity of the LGBT+ community.
- 2.4 At its last meeting, the Hub had a focus on Health and Social Care. It heard from the Director of Adults & Health, representatives from Leeds Teaching Hospitals Trust on behalf of the NHS and Stonewall regarding the Unhealthy Attitudes Report.
- 2.5 Stonewall commissioned YouGov Plc to carry out an in depth survey looking into LGBT+ issues in health and social care settings.
- 2.6 YouGov asked a representative sample of 3001 health and social care staff about their experiences relating to their employment. Respondents came from a range of backgrounds including doctors, nurses, counsellors, carers, managers, receptionists and porters.
- 2.7 The Hub members would like to establish a work stream and sub group specifically looking at the sector and the issues that have been highlighted within the Unhealthy Attitudes Report.
- 2.8 Establishing the delivery mechanism for the action plan as a sub group of the Hub will enable the Health and Social Care agendas to be joined up with other LGBT+ Hub work streams such as around education, community safety and Housing.
- 2.9 The Hub Co-ordinator Geoff Turnbull attended a Health and Wellbeing Board workshop on the 20th of July to have initial discussions around the proposals.

3 Main issues

- 3.1 The Stonewall report highlights the poor experiences of many LGBT+ patients and staff. It identifies a series of recommendations to address these.
- 3.2 Ending LGBT+ bullying and discrimination including:
- Visible campaigns to end homophobic, biphobic and transphobic bullying
 - Bullying and harassment policies that explicitly address LGBT+ issues
 - Complaints procedures that are inclusive of LGBT+ issues
- 3.3 Improving training and development including:
- Mandatory LGBT+ awareness training, including around bullying
 - Professional bodies to ensure they include LGBT+ awareness in their curricula
- 3.4 Supporting LGBT+ staff in the workplace including:
- Clear messages that bullying and harassment around sexual orientation will not be tolerated
 - Support for staff networks
 - Celebrating and supporting LGBT+ role models
- 3.5 Improving LGBT+ patient experiences including:
- Addressing issues relating to so called 'gay cures'
 - Equality monitoring to include sexual orientation
 - Ensure LGBT+ inclusive resources are available for staff and patients
- 3.6 Leadership support for LGBT+ equality including:
- Leaders in organisations should highlight positive work done in their organisation
 - Make boards as fully inclusive as possible
 - Leadership programmes to include LGBT+ awareness

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 Work on this agenda has been subjected to public consultation and engagement at previous Hub meetings and the Sub Group will continue to consult and engage as the proposed action plan is delivered as appropriate.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 The report content is directly related to work around equality and diversity and as such no equality impact assessment has been undertaken.

4.3 Resources and value for money

- 4.3.1 The work of the Hub is supported by Leeds City Council Communities Team. No immediate financial implications in establishing the Sub Group are anticipated other than Officer time however delivering the actions may incur costs for each partner organisation in the future.

4.4 Legal Implications, access to information and call In

- 4.4.1 There are no legal implications. All public sector bodies are however bound by the Public Sector Equality Duty and are required to give 'due regard' to equality, including LGBT+ equality, in the delivery of their services and these proposals will assist partner organisations in meeting these obligations.

4.5 Risk management

- 4.5.1 There are no specific risk management issues identified for the project at this stage.

5 Conclusions

- 5.1 The evidence provided by the Stonewall report and other work in this area such as that undertaken by the LGBT+ Foundation in Manchester and the recent LGBT+ Mapping Report here in Leeds supports the desire by organisations across the health and social care sector to do more work to deliver more inclusive employment and customer experiences for LGBT+ people.

6 Recommendations

The Health and Wellbeing Board is asked to:

- 6.1 Support the establishment of a Sub Group of the LGBT+ Hub focusing on Health and Social Care and nominate representatives from each partner organisation to attend this.
- 6.2 Task the LGBT+ Hub Sub Group on Health and Social Care with developing an action plan to deliver the recommendations of the Unhealthy Attitudes Report.
- 6.3 Task the Sub Group with identifying any additional actions that may need to be delivered to ensure Health and Social Care services are fully inclusive for LGBT+ people.
- 6.4 Task the Sub Group with consulting and engaging with the LGBT+ community as required to deliver the action plan.
- 6.5 Agree to receive regular update reports on progress in delivering the action plan.

7 Background documents

- 7.1 None.

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How does this help reduce health inequalities in Leeds?

The experiences of patients highlighted within the Stonewall report is of concern. Patient perception and experience links directly to their likelihood in initially seeking early treatment, their likelihood to engage in long term health care treatments and their recovery from ill health. We also know that LGBT+ people face some particular health care challenges such as higher levels of smoking and alcohol consumption, women's health issues and mental health. In addition the Trans community can have significant engagement with health services.

How does this help create a high quality health and care system?

The Health and social care sectors are experiencing significant pressures on recruitment. Organisations that provide an inclusive environment for their staff to be themselves at work are more likely to be able to recruit and retain staff to provide the levels of service that we wish to see in the sector in Leeds.

How does this help to have a financially sustainable health and care system?

Future challenges or opportunities

The model adopted for this work around LGBT+ communities could be adopted for other equality areas if proven to be successful.

**Priorities of the Leeds Health and Wellbeing Strategy 2016-21
(please tick all that apply to this report)**

A Child Friendly City and the best start in life	
An Age Friendly City where people age well	
Strong, engaged and well-connected communities	
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	
A stronger focus on prevention	
Support self-care, with more people managing their own conditions	
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X

Leeds Health and Wellbeing Board



Report author: Dr Jane Mischenko
(Lead Strategic Commissioner:
Children & Maternity Care, NHS
Leeds CCGs Partnership)

Report of: Susan Robins (Director of Commissioning NHS Leeds CCGs Partnership) & Steve Walker (Director of Children & Families, Leeds City Council)

Report to: Leeds Health and Wellbeing Board

Date: 28th September 2017

Subject: Annual refresh of the Future in Mind: Leeds Local Transformation Plan for children and young people's mental health and wellbeing

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ 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

Future in Mind: Leeds is a single overarching strategy, underpinned by the Future in Mind: Leeds Local Transformation Plan (LTP). Last autumn the Health and Wellbeing Board had a very positive discussion and endorsed the strategy and LTP.

Our strategy brings together the Leeds response to the recommendations from the Department of Health's publication Future in Mind (2015) and the duties within the Children & Family Act (2014), in terms of the SEND requirements for pupils with Social Emotional and Mental Health needs.

The purpose this year is to review and endorse the refreshed LTP (Appendix 1). The refresh of the LTP sets out achievements to date against this challenging programme and the priorities and next steps over the next two years.

Recommendations

The Health and Wellbeing Board is asked to:

- Support, approve and champion the Future in Mind: Leeds strategy and underpinning Local Transformation Plan (LTP). The refresh of our LTP has to be published on NHS Leeds CCGs and council websites by the end of October 2017 (NHSE requirement).
- Recognise and share the achievements to date (detailed in the plan), progressed in the first years of the Future in Mind LTP funding allocations.
- Endorse how the child and young person's voice has been integral in developing the priority work-streams and going forward is embedded in the co-production of their delivery.
- Discuss how they will support the delivery of the vision, the strategy and underpinning plan.

1 Purpose of this report

- 1.1 This report is an update on how we are driving forward our ambitious strategy to transform how we support and improve the emotional and mental health of our children and young people and therefore, ultimately impact on the wellbeing of all of our population.
- 1.2 The report is the annual refresh of our Local Transformation Plan, which we need to refresh on an annual basis and publish on council and CCG websites (NHSE requirement).

2 Background information

- 2.1 The mental health of children and young people is a priority within the Joint Health and Wellbeing Strategy (2016-2021) and the Leeds Children and Young People's Plan (2015-2019) and is also integral to the Leeds Health and Social Care Plan (2016-2021).
- 2.2 The commitment of the council is clearly demonstrated with the £45m investment into world-class specialist education provision for children and young people who due to social, emotional and mental health needs require additional support in their learning. The specially designed buildings and the nurturing ethos that informs this provision will significantly improve outcomes of one of the most vulnerable cohorts of children and young people.

The 3 CCGs in Leeds invested the ring-fenced funding allocation received from NHSE, circa £1.5m, to initiate the transformation of social, emotional and mental health support and services, following assurance of our LTP in 2015. The continued commitment of the CCGs to this critical agenda is demonstrated in the continuation of that investment in 2016/17 and 2017/18.

3 Main issues

- 3.1 Our vision is to develop a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills to support their needs.
- 3.2 To achieve this in a context of tightening resource and evidence of increasing demand we need to work together in a single approach and to combine and transform our services. The strategy and plan evolve from the already strong relationships across our children's partnership, across health, education, social care and the third sector.
- 3.3 There is a positive and universal focus on wellbeing. We will build resilient communities to support social, emotional and mental health through a citywide continuum of support, thereby preventing and reducing the need for specialist interventions.
- 3.4 Some of our key areas of achievement are highlighted below, many more are within the LTP document:

- The MindMate website won a prestigious gold award at the Design Business Effectiveness Awards (DBA) and is being included as a best practice example in the national Positive Practice for Mental Health Collaborative Directory.
- 151 schools (as of 20/07/17) have registered for the MindMate Champion programme and our locally developed MindMate Lessons (PHSE curriculum) launched in May 2017.
- Joint funding of our MindMate Wellbeing service (school cluster) by schools, CGGs and Local Authority is agreed for the next 3 years.
- There is an established SEMH panel to support improved learning pathways reducing number of school exclusions in the city.
- The new specialist education school buildings project is on track (creating capacity for 340 specialist SEMH places in Leeds).
- There is swift access to specialist CAMHS (average wait of 6 weeks).
- The new CYP community eating disorder service is established and is on track to support the expected number of young people and delivery of the national access targets.
- West Yorkshire and Harrogate STP has been successful in their bid for New Models of Care CAMHS with LCH acting as the lead provider.

3.5 Key priorities for the remainder of this year and for 2018/19 are:

- MindMate Ambassadors programme will commence in the autumn 2017, where young people are supported to formally co-produce and promote/represent the website.
- Develop and agree an enhanced MindMate SPA model, to include self-referral and brief intervention approaches, in co-production with key stakeholders across the system.
- Ensure there is a coherent response and dedicated team for children and young people in mental health crisis, in development with the WY&H STP New Models of Care CAMHS work.
- Develop a workforce plan to underpin Future in Mind: Leeds strategy and LTP.

4 Health and Wellbeing Board governance

- ### 4.1
- The governance chart (appendix 1 of the Leeds LTP) details the working groups and reporting structures. The key delivery and governance structure for this work is the Future in Mind: Leeds Programme Board made up of officers and leads from across the programme of work and chaired by the Executive Lead Councillor for Children and Families.

4.2 Consultation, engagement and hearing citizen voice

- 4.2.1 The voice of children, young people and the views of their parents' have strongly informed our key priorities. The task groups continue with this principle in the delivery of the priorities.
- 4.2.2 An example is where young people have led from the start the content, design and language of the MindMate website and now regularly co-present at local, regional and national conferences.
- 4.2.3 We continue to use Healthwatch and Common room to consult with young people and families on progress to date and what we need to improve further. Children and young people supported us to develop a quick guide to our strategy and the programme board recently heard how young people propose to hold us to account in the delivery of our plan.

4.3 Equality and diversity / cohesion and integration

- 4.3.1 As reflected in the national Future in Mind (2015) publication there has to be an additional effort in Local Transformation Plans to respond to the needs of certain vulnerable groups of children and young people. In Leeds there are examples of multi-agency services supporting young people in the youth justice system and care system.
- 4.3.2 A specific priority in our LTP is to continue to review and check that the needs of vulnerable young people are met. This is supported by the intelligence gathered by the commissioned Future in Mind: Leeds Health Needs Assessment (2016).

4.4 Resources and value for money

- 4.4.1 There are strong principles underpinning our plan that will maximise the best use of resource and best value for money; these are listed below:
 - Prevention (following the principles of the WAVE report)
 - New ways of working to develop emotional resilience and support self help
 - Early support/help to prevent escalation
 - Evidence based practice
 - Use of digital technologies
 - Transforming existing services and combining resources across the partnership to prevent duplication
 - Noting that getting it right in childhood supports reduced need and demand in adulthood

4.5 Legal Implications, access to information and call In

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

4.6 Risk management

- 4.6.1 The programme board reviews the risks to the delivery of the strategy and LTP every time it meets. The key risks reflect those known nationally, reducing resource but rising demand, rapidly changing policy across education, health and social care, and workforce challenges in recruiting the staff with the right skills. Mitigation is in place and constantly reviewed for all of these areas.

5 Conclusions

- 5.1 The first 24 months of delivery of the Leeds Local Transformation Plan is already demonstrating progress against key priorities (as reflected in the refreshed plan).
- 5.2 This refreshed plan creates even more opportunities to drive forward the transformation we need and to deliver our vision.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Support, approve and champion the Future in Mind: Leeds strategy and underpinning Local Transformation Plan (LTP). The refresh of our LTP has to be published on NHS Leeds CCGs and council websites by the end of October 2017 (NHSE requirement).
- Recognise and share the achievements to date (detailed in the plan), progressed in the first years of the Future in Mind LTP funding allocations.
- Endorse how the child and young person's voice has been integral in developing the priority work-streams and going forward is embedded in the co-production of their delivery.
- Discuss how they will support the delivery of the vision, the strategy and underpinning plan.

7 Background documents

- 7.1 None.

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How does this help reduce health inequalities in Leeds?

There is a clear commitment to prioritise targeting support to vulnerable groups of children and young people at higher risk of social emotional and mental health needs. (Priority 6)

How does this help create a high quality health and care system?

There is an established partnership steering group focusing on developing evidence based approaches, shared outcomes and the participation of children and young people across all SEMH services in Leeds (the HOPE group). (Priority 11)

How does this help to have a financially sustainable health and care system?

There are strong principles underpinning our plan that will maximise the best use of resource and best value for money; these are listed below:

- Prevention (following the principles of the WAVE report)
- New ways of working to develop emotional resilience and support self help
- Early support/help to prevent escalation
- Evidence based practice
- Use of digital technologies
- Transforming existing services and combining resources across the partnership to prevent duplication
- Noting that getting it right in childhood supports reduced need and demand in adulthood

Future challenges or opportunities

**Priorities of the Leeds Health and Wellbeing Strategy 2016-21
(please tick all that apply to this report)**

A Child Friendly City and the best start in life	☐
An Age Friendly City where people age well	☐
Strong, engaged and well-connected communities	☐
Housing and the environment enable all people of Leeds to be healthy	☐
A strong economy with quality, local jobs	☐
Get more people, more physically active, more often	☐
Maximise the benefits of information and technology	☐
A stronger focus on prevention	☐
Support self-care, with more people managing their own conditions	☐
Promote mental and physical health equally	☐
A valued, well trained and supported workforce	☐
The best care, in the right place, at the right time	☐

Future in Mind: Leeds Local Transformation Plan, 2016 – 2020
September 2017

This plan should be read in conjunction with the Future in Mind: Leeds Strategy; this is the high-level implementation plan of that strategy. This plan sets out achievements to date and the key deliverables to be delivered in 2017/18, 2018/19 through to 2019/20 and will continue to be refreshed on an annual basis. This plan is supported by the publication of headline information on spend, activity and workforce for 2014/15, 2015/16 and 2016/17. Waiting times are also provided for the first time in this refresh (Appendix 4).

This plan is a Leeds component of the West Yorkshire and Harrogate (WH&H) STP and critically aligns with the developments underway since the successful bid to be a wave 2 New Models of Care for CAMHS.

The plan supports the commissioning for good mental health and wellbeing for Leeds children and young people by investing in emotional resilience, early help and intervention and quick access to more specialist support when required. Key outcomes and KPIs are set out within the plan and inform the Future in Mind: Leeds dashboard.

Priority 1 - Develop a strong programme of prevention that recognises how the first 1001 days of life impacts on mental health and wellbeing from childhood through to adulthood (The full programme of activities can be found within the Leeds Best Start Plan)			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Jane Mischenko/ Sharon Yellin	HNA PNMH completed and PNMH pathway published Perinatal Mental Health service user reference group established to lead stigma programme and contribute to wider programme. Joint clinics/ training and protocols between obstetrician, specialist midwife and perinatal mental health (PNMH) psychiatrist in LTHT Infant Mental Health Service (IMHS) funded by LYPFT to work with Leeds PNMH Mother and Baby unit Additional psychology resource for Infant	Workforce development plan to support implementation of PNMH pathway agreed and commenced Anti-stigma campaign for PNMH issues to be launched Use of social media to promote key Best Start messages (including Facebook and twitter) Annual Baby week in September to promote importance of this life stage, best practice and support/ services for families	New Models of Care developed for practices with high levels of vulnerable children and families (safeguarding), aiming to break the intergenerational cycle of ACE)* Integrated maternity pathway for young parents completed Increased integration of services (between health visiting, children centres and midwives) at the point of delivery to families Review and development of citywide perinatal education offer 2018/19

* ACE: Adverse Childhood Experiences evidenced to impact on whole life outcomes and into the next generation

Appendix 1

Priority 1 continued	Mental Health Service commissioned recurrently IMHS attachment training to adult mental health professionals delivered Implementation of Best Beginnings Baby Buddy app (with localised information) as part of Northern impact study Leeds parents and babies feature in locally commissioned 'Understanding Your Baby' component of Baby Buddy app Evaluation report of Best Beginnings implementation complete and published 44 MindMate links in Children centres (as of 20/07/17) Inaugural Baby Week (UNICEF) held in Leeds in September 2016 Delivery of Leeds Baby Steps programme (targeted perinatal education programme for families with additional needs)	Leeds baby box scheme launched, with targeted work to promote take-up by families in most need Re-procurement of 0-19 Healthy Child Pathway services (delivery of priorities within Best Start Plan and PNMH pathway will be integral to this) Revised children's centre offer in the city (MindMate Champion accreditation integral to this)	
Child and Young People & Parent Voice: Co-production of PNMH pathway and offer with women and families. Leeds parents feature in the Best Beginnings Baby Buddy app			
Key performance Indicator: Placeholder: Additional number of women receiving specialist perinatal care compared to baseline % of Children's Centres with MindMate Links % of Children's Centres with MindMate Champion accreditation			
Workforce: PNMH workforce development plan IMHS training programme MindMate Champion subsidised training offer Think Family training			

Appendix 1

Priority 2 - Work with young people, families and schools to build knowledge and skills in emotional resilience and to support self-help			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Jane Mischenko /Sharon Yellin	MindMate website co-produced with young people – provides details of support in the city, (narrative and animations), information and self-help tools – see mindmate.org.uk MindMate website won the prestigious gold award at the Design Business Effectiveness Awards (DBA) Parent page of MindMate website (developed with parents and carers) uploaded Animations of CAMHS, The Market Place and Therapeutic Social Work Service services in Leeds added to MindMate website ‘I feel angry’, ‘I feel different’ and ‘body image’ pages written and uploaded to MindMate website Anti-Stigma (local Time to Change) plan agreed (co-produced with CYP) (Space2 provider); work started 20 schools have received the “Fix this” play as well as shortened version presented at the resilience conference. 151 schools (as of 20/07/17) have registered for the MindMate Champions programme School Health Check tool used for schools to self-assess if MindMate friendly Publication of MindMate Champion subsidised training offer to schools November 2016 8 settings have achieved the MindMate Friendly award.	Develop further the self-care/interactive games and tools component of the MindMate website Accreditation of MindMate Champion settings Interactive MindMaze board and digital tool launched Work with regional NHSE Clinical Network to develop competencies for school workforce Commissioned Evaluation of anti-stigma campaign: reports October 2017 Rollout of MindMate Lessons (PHSE curriculum) Launch of Trylife play early in 2017/18 York MBSR to produce a Mindfulness in Schools programme (co-produced with 5 primary schools, a SILC and FE college and 2 secondary schools) by July 2017 Mindfulness in Schools pilot report March 2018 Mindfulness in School programme condensed and embedded in MindMate Lessons	Continued development of the MindMate website Continued rollout of the MindMate Champion programme Review work in the city to support parents/carers re: emotional resilience and self-help

Appendix 1

Priority 2 continued	MindMate Lessons (PHSE curriculum for social, emotional and mental health) launched on 3rd May 2017 MindMate Lessons available on the MindMate website through a secure log in Feasibility study of Mindfulness in schools programme completed Adapted Headspace course written and evaluation received Conference on emotional resilience delivered by Boing Boing and local leaders in Education Psychology held in October 2016 (250 front line school and social care staff attended) Children's Social Care established Family Group Conferencing Restorative approaches being used to engage with families to come up with solutions to problems	The Leeds evidence based parenting offer to be agreed Continued delivery of plan for anti-stigma work Social media plan to be developed to promote MindMate.org.uk more widely Additional pages to be added to the MindMate website in response to suggestions made by young people including pages on sleep and a map of how the whole system works MindMate Ambassadors programme to commence in Autumn 2017 – where young people are supported to co-produce the content of mIndmate.org.uk	
Child and Young People's Voice: Content, design and development of MindMate website led from the start by CYP and new Ambassador role will formalise this CYP integral to development of MindMate self-help tools and games MindMate Lessons (curriculum) content informed by what CYP said was critical 'Fix This' play developed in consultation with CYP Content of anti-stigma campaigns led by CYP			
Key Performance Indicators: Number of MindMate website visits Placeholder: MindMate website indicator – linked to use of self-help tools/resources % of schools MindMate Friendly % of schools to achieve MindMate Champion accreditation			
Workforce: MindMate Champions programme Resource pack of practical tools to promote resilience to be produced			

Appendix 1

Priority 3 - Continue to work across health, education and social care to deliver local early help services for children and young people with emotional and mental health needs who require additional support			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Andrew Eastwood/ Jane Mischenko / Sal Tariq	25 school clusters in place across the city and the majority have an early help offer, commissioned from a range of NHS and 3rd sector providers for CYP with SEMH needs SEMH data report complete of 12 months data from school clusters (of presenting SEMH need, service offer and impact) Clear commissioning framework for NHS, LCC and schools in the city to deliver the MindMate wellbeing offer (SEMH cluster). This is agile in recognition of changing and variable forms of school networks) with finance and formula for distribution agreed for three years (2017/18, 2018/19 and 2019/20) Joint commissioning of The Market Place by NHS and LCC for youth work and counselling provision Pilot of rapid access to counselling at The Market Place completed and service commissioned for a further year Developed a city-wide partnership approach to alternative educational provision for SEMH in Leeds There is joined up planning and sharing of information and a quality assurance report on AIP provision complete DfE Innovation bid to develop Restorative Early Support Teams successful. This will develop Early Support teams, aligned with clusters, to be led by social workers	Review protected groups and ensure early help offer in Leeds accessible and acceptable for them – address if inequity Continue to strengthen the relationship between clusters and Area Inclusion Partnerships to improve the core offer of targeted support for children, young people and families Identify opportunities to maximise workforce between clusters and AIPs Restorative Early Support Teams, aligned to clusters, to be led by social workers to provide coordinated support for children, young people and their families to be developed first in top 6 most needy clusters Work to ensure that the number of CYP supported by clusters for SEMH is fed into the MHSDS Work with the University of Leeds on their successful MRC bid to pilot the idea of an information prescription to be offered to young people via a schools setting	Core programme of work from HOPE (Harnessing Outcomes, Participation and Evidence) group will support clusters (MindMate Wellbeing) to develop evidence based practice and capture outcomes Core programme of work from HOPE group will develop training and tools for cluster workforce development A key priority of the HOPE group work is to improve information systems to support the whole system, including clusters

Appendix 1

Priority 3 continued	to provide coordinated support for children, young people and their families Strengthened relationship between clusters and Area Inclusion Partnerships to improve the core offer of targeted support for children, young people and families Established the SEMH Pathways Panel to support improved learning pathways for children and young people at risk of exclusion		
Children and Young People Voice: Consultation of CYP in Leeds by Youthwatch and Young Minds identified need for local accessible services 2015 and repeated in 2017			
Key Performance Indicators: Spend on CYP mental health by NHS, LCC and schools Numbers of CYP accessing early help mental health service (defined as from qualified mental health practitioner – cluster and third sector) Numbers of CYP starting treatment in NHS funded community CAMHS Reduction in % of CYP excluded from school (permanent and fixed term exclusions) Improvement in Attendance Improvement in Achievement Placeholder: increased % alternative provision categorised as good or outstanding Placeholder: % of key protected groups accessing early help service and education measures as above (i.e. Children who are Looked After, BME, CYP in youth justice system, LGBT)			
Workforce: SEMH Pathway Panel briefings for schools and targeted services HOPE Action plan – has a focus on workforce plan for whole system, including clusters (MindMate Wellbeing)			

Appendix 1

Priority 4 - Commit to ensuring there is a clear Leeds Offer of the support and services available and guidance on how to access these			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Jane Mischenko/ Barbara Newton	Single Leeds strategy (Future in Mind: Leeds) incorporating requirements of Future in Mind (DH) and SEND/ SEMH (DfE) and the refreshed LTP is the plan that drives the delivery of this The current Leeds offer of available support and services and how to access these is published as part of the SEND LCC Local Offer and is also integral to the MindMate website Easy to understand animations of services are available on the MindMate website One Minute Guides available for professionals on support and services on offer and how to access them for a range of services developed Quarterly newsletter circulated to professionals across the city to promote the Future in Mind: Leeds programme. Includes 'a day in the life of' professionals supporting SEMH in the city	Local Offer reviewed and updated at least annually Continue to develop the links between MindMate website and the Local Offer Website Extend animations of the service offer on the MindMate website Develop a MindMate page for Real Life Stories to allow young people to see how others have been supported and have coped with emotional challenges Develop a stand-alone presentation to communicate the work of Future in Mind: Leeds for members of the Programme Board to cascade to front line staff	Local Offer reviewed and updated at least annually Continue to develop the links between MindMate website and the Local Offer website Extend the service offer available in easy to understand animations on the MindMate website Continue to develop the catalogue of real life stories
Children and Young People Voice: Consultation with CYP by Youthwatch and Young Minds (2015) informed priorities of Local Offer Common Room supported CYP to have CYP Quick guide version of Future in Mind Leeds Strategy CYP Real Life Stories integral to MindMate website			
Key Performance Indicators: Number on newsletter distribution list			
Workforce: Cascade of One Minute Guides Quarterly Newsletter to health, education and social care staff Communication presentation prepared and cascade to front line staff via programme board members			

Appendix 1

Priority 5 - Deliver a Single Point of Access (SPA) to include assessment and an initial response for referrals that works with the whole Leeds system of mental health services to enable children and young people to receive the support they need, as soon as possible			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Jane Mischenko /Sam Prince	MindMate SPA has been operational for over a year and processes are well established and relationships across the whole system are robust. Monthly reports are received on the number of CYP referred through the SPA, and of the end service destination 3 CWPs appointed into MM SPA July 2017	Develop and agree an enhanced SPA model (in co-production with key stakeholders across the system) Develop a brief intervention and health coaching offer by combining the work of school nurses and CWPs Ensure restorative approach/ health coaching model is integral the whole system of SPA support and service delivery Complete a user consultation (both young people and parents and carers) by end June 2017 Undertake pilot of the online parenting tool Triple P Continue to develop Provider Network to support the development of MM SPA Work with MHabitat to look at pathways to support the roll out of the Happy Vault app developed in Leeds Use intelligence from MM SPA referrals to identify gaps in services – October 2017	Develop self-referral through MM SPA during 2018/19 Continue to investigate ways of offering telephone and online support for young people and parents/carers while they wait for a service
Children and Young People Voice: The SPA was created in direct response to reports by CYP and their families of difficulty of navigating the system to get support Consultation underway (2017) on their experience of the MM SPA CYP and Parents will be involved in the development of the future model			
Key Performance Indicators: Placeholder: Numbers managed by SPA (brief intervention new model) without requiring further service response Placeholder: CYP requiring further service (early help or CAMHS, etc) accessing right service swiftly (detail to be developed)			
Workforce: Restorative Practice training and Health Coaching programme CWP training			

Appendix 1

Priority 6 - Using an integrated approach to ensure vulnerable children and young people receive the support and services they need			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Andrew Eastwood/ Jane Mischenko/ Sal Tariq	Fast tracking process in place for Children who are looked after, or with a child protection plan (via CAMHS psychologists embedded into the TSWS) Films describing some of the challenges of being a Looked After Child and a foster carer are uploaded to the professional tab of the MindMate website. These are used as a workforce training tool for staff across health, education and social care TSWS received additional funds to provide support for Leeds Children who are looked after placed out of area. Training (8 x SafeTALK courses and 1 x applied Suicide Intervention Skills Training – ASSIST) commissioned from Community Links for delivery to key foster carers, children's homes residential staff and YOS staff. Residential course with support re emotional and mental health delivered for care leavers and evaluated well The Market Place commissioned to specifically offer support to care leavers from 2015/16 Health Needs Assessment focus groups were held (by the Common Room) with key vulnerable groups (Gypsy/Traveller group, Youth Muslim forum and LGBT group) Embedded CAMHS nurses (4) within YOS team. Work taken place within 2016 to enable fast track to specialist CAMHS support if required	Commission and extend remit of TSWS during 2017/18 to see children placed outside of Leeds. Work with TSWS to enhance their digital offer. Work with regional colleagues in Centre of Excellence bid to secure post adoption therapeutic support As part of all age Transforming Care Programme (TCP) work to develop a dynamic support register of CYP with LD and or autism and mental health needs at risk of admission to an acute bed. In addition develop effective transition pathway as part of TCP; embed and deliver Community Education Treatment Reviews as required and deliver early support and intervention for this cohort of CYP and their families (detailed in Leeds TCP) A focus on transforming outcomes for young people who offend (or are at risk of doing so), who have special educational needs, through supporting professionals to bring about a culture and behaviour change around effective SEND joint working Work with NHSE to ensure communication and pathways are developed between local YOS provision, the new all age liaison and	Review equality of access to whole system of service and support for vulnerable CYP Evaluate the success of the service to deliver care via TSWS to young people placed outside of Leeds Work towards having a CYP intensive Positive Behaviour Service in Leeds (TCP) Work with NHSE to develop clear pathways between the sub-regional CYP SARC and local area provision, paediatric follow up and SEMH support

Appendix 1

Priority 6 continued	Leeds MST supports chronic and violent offenders working in their system of homes and families, schools and teachers, neighbourhoods and friends. CCG co-commissioning 2-year pilot of targeted mental health support in place with SILC cluster commenced in 2016/17	diversion team and the new sub-regional forensic CAMHS team as these latter two are developed in 2017/18	
Children and Young People Voice: Targeted focus groups held in 2016 with vulnerable CYP as part of the Future in Mind HNA			
Key Performance Indicators: Number of young people outside of Leeds (within 80 miles) supported by TSWS Placeholder: Increased % of vulnerable groups accessing services (CLA, YOS, LD)			
Workforce: Film of CYP in the care system for use in workforce development Safe TALK training ASSIST training			

Appendix 1

Priority 7 - Ensure there is a coherent citywide response to children and young people in mental health crisis			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Jane Mischenko/ Sal Tariq/ Kashif Ahmed	As part of CORE 24 work pump priming is supporting new posts - Specialist Practitioners in liaison psychiatry are working in emergency departments (out of hours) with all-age (16+) CAMHS continue to deliver a four-hour response to those young people presenting in the emergency department in crisis (self-harm/ psychosis) Section 136 Suite for CYP opened in Leeds 2016 Staff training programme in place for EIP service Over 2 years since a CYP has been held in a police cell when in mental health crisis in Leeds Key event held with stakeholders (across emergency services, health, education and social care) to initiate work-stream to review and improve whole system response to CYP in mental health crisis September 2016 All age EIP service in Leeds for ages 14-65 seen within 2 weeks of referral and receiving a package of care. Work undertaken with regional clinical network to benchmark service against NICE recommended treatment and standards (current absence of sufficient CBTp and ARMS service) Leeds is a relatively low user of inpatient CAMHS beds, facilitated through the on-going investment in the community outreach team, as part of the core CAMHS model WY&H STP New Models of Care CAMHS wave 2 successful with LCH as lead provider	Key work stream reviewing the whole system offer for CYP who are experiencing a mental health crisis including: • Data pack (of needs, activity and performance) • CYP and parents consultation • Swift access to mental health assessment and handover (in and out of normal hours) • Effective integration/use of all existing resource (CSWS EDT, AMHS, Police response, CAMHS self-harm rota and intensive outreach team) to create the service model • Explore a safe haven provision (alternative to A&E/ 136 suite) Continue to work across the whole system to ensure that there is an effective and compassionate response to young people in mental health crisis 24 hours a day – working group to make recommendations to a workshop in September 2017 Work closely with the project team of the successful WY&H STP bid of CAMHS New Care Models Further development of EIP service to deliver access to CBTp and ARMS service. Confirm clear pathway in place no matter where CYP present e.g., SPA	Implement a crisis team in Leeds in development with the WY&H STP New Models of Care CAMHS work

Appendix 1

Priority 7 continued

Child and Young People Voice:

A consultation with young people and parents who have experienced a mental health crisis has been commissioned

Key Performance Indicators:

Hospital admissions for self-harm rate per 100,000 0-17 (inclusive)

Number of CYP s136 detentions taken to police cell as a place of safety

Number of CYP held in suite 136 in mental health crisis

Number of CYP admitted to paediatric bed in mental health crisis

Placeholder: Number of CYP in adult in-patient wards

Placeholder: Number of CYP bed days in adult in-patient wards

Number of CYP in tier 4 bed per CYP population

Number of CYP bed days in tier 4

Workforce:

Training and protocols in place between CAMHS and acute paediatric settings (A&E and paediatric wards)

Training and protocols in development between new A&E mental health practitioners (core24) and CAMHS

Further workforce development plan to be integral to final report of the review

EIP training programme

Priority 8 - Invest in transformation of our specialist education settings to create world class provision.

Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Andrew Eastwood/ Viv Buckland	Building new schools to deliver 340 specialist SEMH places in Leeds (4-19 yrs provision) agreed Planned Increased primary school capacity is complete LCC committed to invest £45 million into new buildings for specialist SEMH places Converted specialist SEMH provision to the Springwell Academy Leeds	Complete East site building project in creating capacity of 340 specialist SEMH places in Leeds Site completion by: East: January 2018	Complete remaining building projects in creating capacity of 340 specialist SEMH places in Leeds South: April 2018 North: September 2018

Child and Young People Voice:

Key Performance Indicators:

Reduction in CYP being placed out of authority for education

Improved attendance at Specialist provision

Improved educational progress

Workforce:

Appendix 1

Priority 9 - Work with children and young people who have mental health needs as they grow up and to support their transition into adult support and services			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Kashif Ahmed / Jane Mischenko/ Barbara Newton	Young Adults page for MindMate website developed with MindMate 16 plus panel and linked to adult MindWell portal Workshop held at FE Colleges event to map pathways to support and promote MindMate website and resources Ch Ch Changes play on transitions from primary to secondary school written and is fully booked by schools and was also shown at Future in Mind: Leeds strategy launch The Market Place and Leeds Mind part of national pilot testing out peer-to-peer support model (led by young adult with life experience). A one-year pilot to extend and develop the model further has been agreed Engagement with young people on “what great looks like” for services 17+ Each adult Community Mental Health Team has identified a young person’s champion (role co-designed with CYP) SEMH Pathway Panel proactively manage transition points Small CAMHS transition team in place for case management of CYP into adult support and services and a tier 4 transitions protocol has been written, to support those in a CAMHS hospital bed in most urgent	Identify mechanisms to increase the flexibility of the pathways between CAMHS and adult mental health services for the transition of young people between services Develop a programme of support for the young people’s champions in adult mental health services Develop a document which describes what it means to be a young people’s champions in adult services Increase the range of options available to young people in primary care for mental health support Review and evaluate the peer-to-peer pilot Ensure continued connection between the MindMate and MindWell sites	Ensure that the transition process is included in the 2018/19 LYPFT contract e.g. young people’s champions in adult services Review the continued commissioning of peer-to-peer THRU support model Extend the number of young people’s champions in adult services to include specialist services in LYPFT and third sector providers (2018/19) Scope the possibility of creating a single offer for young adults from the age 16 – 25 with the commissioners of adult mental health services (2019/20)

Appendix 1

Priority 9 continued	need of care (Working with adult and children commissioners, including NHSE as commissioner of Tier 4 beds) Pilot continues in the student medical practice supporting university students, with mental health liaison workers delivering early intervention support The Well bean café launched and works with people over the age of 16 to provide support in a non-clinical environment to reduce the number of avoidable admissions and permanently change behaviour among people who frequently use A&E inappropriately.		
Child and Young People Voice: MindMate page for young adults developed by CYP CYP members of the transition task and finish group and co-design of YP champion role in community mental health teams A Young Person is key in the leadership of the testing of the THRU peer support model			
Key Performance Indicators: Numbers of CYP supported by the CAMHS transition team to adult service support Numbers of CYP champions in Adult Mental Health Services Number of young people being supported via peer to peer work in the THRU project Reduction in CYP NEET			
Workforce: Training programme for Young People Champions in adult mental health services			

Appendix 1

Priority 10 - Establish a city-wide Community Eating Disorder Service in line with national standards and access targets			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Sam Prince	The CEDS service model, pathway and funding is agreed for a Leeds service commissioned by the 3 Leeds CCGs and children and young people are receiving the agreed pathway of care Recruitment is complete and staff co-located and experienced and interested paediatricians within the acute trust in place. Staff are co-located and the service is offered from three sites across the city. A training programme for universal settings, such as school-based staff, is underway 50% of staff in CEDS have commenced training to be accredited in Family Based Therapy The provider is reporting into the national data collection process and are on track to deliver to expected number of CYP accessing the service and to the established access targets (100% urgent seen within target and 93.8% routine seen within target 30 June 2017 report) Both parents and CYP are involved in the service development	Ensure that the Community Eating Disorder Service meets national standards and access targets To ensure the Leeds CEDS-CYP is part of the national quality improvement programme Work to optimise impact of CEDS-CYP to reduce crisis and inpatient admissions (and monitor the same)	To ensure that there is a clear and smooth transition pathway between CEDS-CYP and the Adult Eating Disorder services Develop digital opportunities to enhance the service offer (2018/19)
Child and Young People Voice: CYP involved in recruitment of CEDS-CYP staff CYP and parents involved in development of the service CYP informed content of MindMate website on body image			
Key Performance Indicators: Placeholder: Proportion of CYP with ED seen within 1 week (urgent) or 4 weeks (routine) Spend on CEDS-CYP Number of CYP with eating disorder admitted to tier 4 bed Number of CYP with eating disorder supported by intensive outreach team			

Appendix 1

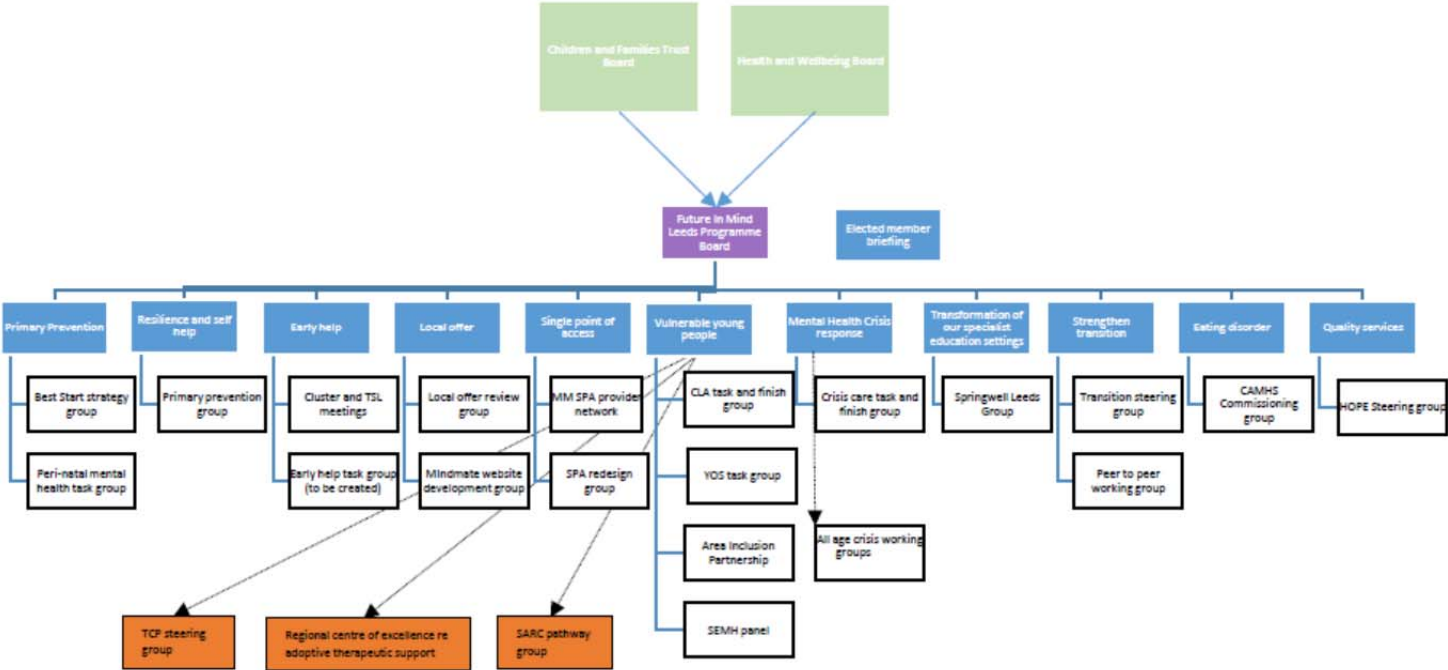
Priority 10 continued Workforce: Training programme for universal staff in schools Primary care targeted communication and training CEDS-CYP specialist team training programme			
Priority 11 - Improve the quality of our support and services across the partnership through evidence based interventions, increased CYP participation and shared methods of evidencing outcomes			
Leadership Team	Achievements to Date	Key Deliverables for 2017/18	Key Deliverables for 2018/19 and 2019/20
Andrew Eastwood/ Jane Mischenko/ Sal Tariq	A formal steering group is in place, named HOPE (Harnessing Outcomes, Participation and Evidence) that reports to the programme board Leeds NHS CAMHS is part of the CYP-IAPT (since wave 3). The HOPE group is focussing on how to share the CYP-IAPT approach across the whole Leeds system of support and services Leeds is part of the CORC national pilot to develop cross-sector outcomes and data linkage across services involved in children and young people's mental health and wellbeing. Further investment has been made by Leeds to increase support from the CORC and EBPu for this priority CORC has worked with clusters, the TSWS and NHS CAMHS to understand current practice in agreeing outcomes with CYP, and recording outcomes in services to use them to greatest effect to improve service quality CORC utilised the 'Understanding Your Model' tool to help different services within the system to clarify their aims, interventions methods, and desired outcomes A comprehensive Future in Mind: Leeds HNA was commissioned and completed in 2016/17	Work to ensure that all NHS funded services are submitting activity data to MHSDS by the end of 2017/18 Workforce initiative to review types of difficulties being referred to agencies, within the whole system and skills both available and required Workforce plan for the Future in Mind: Leeds Strategy to be developed 2017/18 Training to be delivered around outcomes and evidence based services to practitioners and managers across the system Enhanced analysis of outcome data for more SEMH agencies to be undertaken by CORC CORC to support agencies in reporting impact and outcomes HOPE programme action plan on driving forward outcomes and evidence based practice to be completed by end 2017/18	All emotional health services recording outcome data and all services to have clear statements of the high-level outcomes they seek to achieve by end of 2018/19 Progress made on ensuring that all SEMH agency 'core' information systems have outcome recording capacity within them Continued programme to align skill sets in individual agencies with current and emerging referral reasons Training programme to ensure that practitioners can use outcomes and evidenced based approaches in their day to day work

Appendix 1

Priority 11 continued	The Future in Mind: Leeds Dashboard has been produced and approved by the Programme Board There has been a consultation of CYP, parents and professionals re: CYP mental health support and services undertaken by YouthWatch and Common Room). Findings were submitted to the March 2017 Programme Board	Establish Future in Mind: Leeds Dashboard regular reporting (2017/18)	
Child and Young People Voice: Commitment that CYP participation is integral to our definition of quality to agree care plan and goals An annual consultation takes place with CYP and parents to hear of their experience of support and services in the city (commissioned from Youth watch & Common Room) Youth watch worked with CYP to identify the method they wish to hold the Future in Mind: Leeds programme board to account. This was presented and agreed at the July programme board			
Key Performance Indicators: Future in Mind Dashboard provides an overview of progress in Leeds of the strategy and plan Placeholder: proportion of CYP showing reliable improvement in outcomes following mental health service intervention Placeholder: proportion of CYP meeting their mutually agreed goals against number of CYP accessing services			
Workforce: Numbers of staff completing CYP-IAPT courses Delivery of workshops to local areas/clusters promoting evidence base, participation and value of outcome monitoring			
Cross cutting themes: 1. We recognise that improving the Social Emotional and Mental Health of children and young people in Leeds needs everyone to play their part 2. We will work together to plan and deliver our strategy and make best use of our collective resources to improve the experience and outcomes of children and young people with social emotional mental health needs. 3. In direct response to the request from children and young people we will maximise the opportunities digital technologies offer us, whilst safeguarding children and young people from some of the risks the Internet poses.			
Communication and governance In delivering the plan we need to: • Engage young people and families to co-produce communication to ensure we use a language they understand • Effectively communicate with all key partners, including frontline staff • Develop a workforce plan to ensure delivery of the strategy and local transformation plan (to be completed in (2017/18) • Develop a clear governance structure for the assurance of work streams through an effective Programme Board and through to the Children and Families Trust Board and the Health and Wellbeing Board			

Appendix 1

Appendix 1: Governance structure



Appendix 1

Appendix 2: Baseline information

Increased investment

	14/15 (£)	15/16 (£)	16/17 (£)
Core service funding for direct delivery (CAMHS, The Market Place, MST, school clusters, Therapeutic Social Work Service) and MindMate SPA	11,464,353	11,898,500	15,855,188
In addition, there was one off funding in core services to pump prime school cluster commissioning and targeted waiting list initiatives across the system of provision	1,500,000	526,486	1,420,000
Additional funds Leeds has been able to attract to support core services (non-recurrent)			493,500

Funding into services that support direct contact with children and young people who have social, emotional and mental health needs has increased between 2014/15, 2015/16 and again in 2016/17. In core services, this amount has risen from £11.5 million recurrent spending by both the CCGs in Leeds and Leeds City Council to £15.9 million. In addition to this there is the considerable investment from school clusters over the same time (circa £1.5 million per annum).

There have been several examples of non-recurrent investment to support the whole system to transform. In 2014/15 this was a significant part of our investment with £1.5 million being devolved to local school clusters to improve their local offer to children and young people. In 2015/16 over half a million was committed and in 2016/17 nearly £1.5 million pounds has been provided to increase face to face contacts, to drive transformation and to enable services to respond to increasing waiting lists, partly due to the introduction of the SPA.

Increased numbers of Children and Young People seen:

	14/15 (number accepted into services)	15/16 (number accepted into services)	16/17 (number accepted into services)
Core service activity (CAMHS, The Market Place, MST, school clusters, Therapeutic Social Work Service)	6993	7694	8919

Appendix 1

The MindMate Single Point of Access is supporting an improved and swifter pathway from referral to the right service. The service has also started to identify the numbers of young people who are not able to receive a service and we are currently working to understand whether this is because no service exists or if it is that all services have been offered.

1225 additional children and young people are being supported by core services in the city in the last year, this in addition to the **701** increase seen between 2014/15 and 2015/16. Some of this increase can be explained by the additional investment to reduce waiting lists in the city for a number of core services. The majority of the increase is seen in the clusters (and probably represents an improvement in recording of these young people as well as an increase in the number being seen).

Children and Young People requiring admission to a mental health bed

	14/15	15/16	16/17
Occupied bed days	2089	2814	4465
Total number of new admissions	26	37	43

The occupied bed days in Tier 4 beds increased from 2814 (15/16) to 4465 (16/17). This was for a total of 43 young people. This increase is due to an increase in numbers of young people requiring in-patient care but there is also a small cohort of young people requiring a Tier 4 bed for a long period of time. There is significant work underway at the moment as Leeds is part of the Wave 2 New Care Models and we are working to fully understand this data and put in services to ensure we appropriately avoid, or shorten, admissions as much as we can. CCG commissioners are reviewing the current increase in need for inpatient beds and working with NHSE commissioners to understand the particular needs presenting.

Increased numbers of mental health practitioners:

	14/15 (wte staff as of June 2015)	15/16 (wte staff as of June 2016)	16/17 (wte staff as of June 2017)
Core service workforce (CAMHS, The Market Place, MST, school clusters, Therapeutic Social Work Service) and SPA	125.76	163.3	204.7

41.4 more practitioners are in place this in addition to the **38** increase seen between 2014/15 and 2015/16. The increased investment into services is demonstrating an increase in practitioners delivering face-to-face services to children and young people. This increase is across a full range of staff from those delivering local psychological support into schools, to those providing counselling at the Market Place and practitioners within specialist CAMHS.

Appendix 1

Appendix 3: Future in Mind: Leeds Local Transformation Plan – Issues and risks to delivery

The issues and risks below are issues proactively owned and managed by the programme board. There is no risk that has led to the delay of any key priority within the LTP but we include the issues we identify as potential challenges and our mitigation of these for completeness.

CCG Name: Leeds CCGs Partnership				
LPS Number	Description of local priority scheme	Description of issue of risk to delivery plan	Mitigating Actions	*Date expected to deliver
N/A	Cross cutting	Impact of significant Local Authority Budget pressures and <u>potential</u> impact on support networks for children and families in the city.	Cross partnership working in all LTP priority areas to ensure best use of available resource. Significant investment of LTP allocation in first 1-2 years to develop capacity and capability in universal and targeted services and digital resources.	N/A
6.	Vulnerable children (SEND)	The pressures to the High Needs Block funding that supports pupils with complex needs (SEND) with SEMH needs was flagged at the programme board.	Review of the high needs block Additional funds were identified to support those CYP with exceptional SEMH needs – accessed via the SEMH panel. This remains under review.	N/A
3.	Local Delivery of Early Emotional Help Services	Recognition that the whole system Leeds approach and continuation of the model depended upon continued engagement by schools and clusters.	Commitment of funding by CCGs and LA now in place for the cluster model for the next 3 academic years Additional work with clusters – layering resource around this model, such as REST teams and support with adolescents Ongoing support to schools in their universal offer, with MindMate Champion programmes, subsidised training and MindMate Lessons	Cluster model continues to be delivered – issue continues to be proactively managed.
N/A	Cross cutting	Autism Assessment waiting time – delivery of NICE standard of 12 weeks delayed. Currently at 26.8 weeks	Detail within report (increase in referrals impacted on delivery) – significant work underway – additional NHSE funds in 2016; additional clinics established including Saturdays, supported by short term use of an external agency	December 2017

Appendix 1

Appendix 4: Waiting Times

Improving access and reducing waiting times has been a focus across the whole system of social, emotional and mental health services. Additional funds have been provided to school clusters with greater demand and to The Market Place to reduce their waiting times. More detail is provided below for NHS CAMHS:

- The CQUIN within the CAMHS service for 2015/16 to drive down waiting times for the consultation clinics has been very successful. This has achieved its target and been sustained; these waits are now all below 12 weeks
- Investment by a successful NHSE bid - in a waiting list initiative for autism assessments; a recovery plan supported waiting list additional funding is in place with a target of meeting the 12 week NICE waiting standard by December 2017

	General CAMHS	Autism Assessments
Numbers waiting	212	200
Average length of wait (weeks)	5.84	26.8

Waits as of end 30/07/17

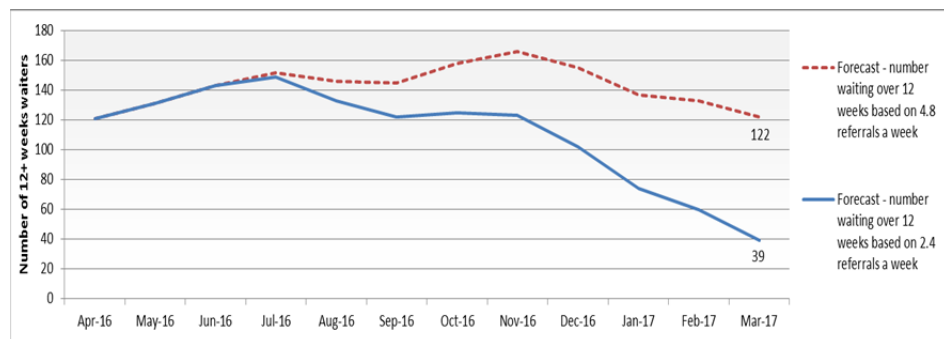
7.1 Additional waiting list NHSE monies - autism

LCH has undertaken extensive work to reduce the number of young people waiting for autism assessments, and the time it takes to complete the assessment. The total number of young people waiting for assessment has reduced from a peak of 233 to 200 but this is higher than the end March position of 193. Both the average length of wait and the longest wait have increased.

The team are running 4 clinics per week and continue with the Saturday clinic that is popular with parents. This increases capacity by 1-2 clinics a week. They have also contracted with an external agency to complete 20 assessments by the end of August; if this proves successful they will contract for a further 80 assessments by the end of December.

The demand remains higher than in the original modelling. There was a 35.4% increase in referral rate between March 2016 and February 2017. Partners welcome this referral increase as this better correlates with the expected referral rates (incidence) expected for a population the size of Leeds. However, this increase has impacted significantly on resource available to diagnose children and young people. The service has now remodelled how it would have met demand if it had remained at previous levels and for the level now being seen. This is shown in the chart below.

Appendix 1



Given the rise in demand the 12-week target is likely to be achieved by December 2017 (subject to current assumptions) and the service continues to address the shortfall in capacity and monitor performance on a regular basis in conjunction with commissioners.

Eating Disorder Wait Times

Summary of Waiters from Eating Disorder Service Quarterly Unify Submission

-4 week target for routine (non urgent) referrals

-1 week target for urgent referrals

Quarter 1 2017-18 (01-April-17 to 30-June-17)

Priority		Wait in Weeks													TOTAL	% of waiters seen within target
		0-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	9-10	10-11	11-12	12+		
Routine	Completed pathways (episodes started in Period)	3	3	10	7	1	1								25	92.0%
	Incomplete pathways (waiters as at 30-June-17)	1	4	2											7	100.0%
Urgent	Completed pathways (episodes started in Period)	2													2	100%
	Incomplete pathways (waiters as at 30-June-17)														0	-

Notes on waiting time target breaches:

Completed pathways (episodes started in period):

1 patient cancelled appointment booked for 26-Apr-17 (would have been 2.3 week wait time at this date)

1 patient where 1st appointment was 4.1 weeks after the referral received date

Incomplete pathways (waiters at quarter end):

All waiters are under the target wait time

% Routine waiters seen within target	93.8%
% Urgent waiters seen within target	100%
% of all waiters seen within target	94.1%

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Leeds Health and Wellbeing Board



Report author: Dawn Bailey
Head of Public Health – Health
Protection. Adults and Health

Report of: Ian Cameron (Director of Public Health, Leeds City Council)

Report to: Leeds Health and Wellbeing Board

Date: 28 September 2017

Subject: Leeds Health Protection Board Annual Report

Are specific geographical areas affected? If relevant, name(s) of area(s):	☒ 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

This paper provides the Health and Wellbeing Board with the second annual report of the Health Protection Board since it was established in June 2014.

The role of the Leeds Health Protection Board is to undertake the planned new duties to protect the health of the population as laid out in national guidance and in the local West Yorkshire Health Protection Specification (April 2015). Since 2014 the Leeds Health Protection Board has been leading programmes of work, focusing on identified emerging health protection priorities for Leeds. An annual work plan has been developed by members of the Board and good progress has been made against all areas.

In addition, the Leeds Health Protection Board has worked to ensure that arrangements are in place to protect the health of communities, meeting local health needs across Leeds through the development of robust assurance frameworks. This includes a health protection indicators report, associated reporting systems, strengthened governance arrangements and the formation of the Leeds Health & Social Care Resilience Group.

In June 2017 the Health Protection Board reviewed and refreshed the priorities, taking into consideration progress and achievements made.

The refreshed priorities identified by the Board in 2017:

- To reduce the incidence of TB
- To reduce the impact of poor air quality on health
- To develop a Leeds outbreak plan
- To reduce the incidence of health care associated infections
- To tackle antibiotic resistance in Leeds
- To reduce excess winter deaths in Leeds

Recommendations

The Health and Wellbeing Board is asked to:

- Note the Health Protection Board's Annual report.
- Note the key progress made against the priorities identified in the Health Protection Board Annual report 2014/15.
- Note the new priorities identified by the Health Protection Board for 2017/20.

1 Purpose of this report

- 1.1 The purpose of this report is to provide the Health and Wellbeing Board with the second annual report of the Health Protection Board, outlining progress made on the existing Board priorities and to inform the Health and Wellbeing Board of the new priorities identified for 2017/18.
- 1.2 The Health Protection Board identified emerging health protection priorities in 2015 for Leeds and developed an annual work plan and dashboard endorsed by members of the Board. This report does not cover all areas under the jurisdiction of the Health Protection Board but only those that have been identified as priorities. The Board does however gain assurance from lead organisations on all health protection priorities and monitors performance through a health protection indicators report. A summary of which, based on national outcomes indicators, is provided in this report as appendix 1.

2 Background information

- 2.1 In March 2014, the Leeds Health and Wellbeing Board agreed to establish the Leeds Health Protection Board in line with Department of Health recommendations. The role of the Health Protection Board is to undertake the duties to protect the health of the population as laid out in national guidance and in the local West Yorkshire Health Protection Specification (April 2014).
- 2.2 The Board undertakes the Leeds City Council duties under the Health and Social Care Act 2012 to:
- Be assured of the effective and efficient discharge of its health protection duties;
 - Provide strategic direction to health protection work streams in ensuring they meet the needs of the local population;
 - Provide a forum for the overview of the commissioning and provision of all health protection duties across Leeds.
- 2.3 The Board is chaired by the Director of Public Health. Members are represented from Leeds City Council services including Environmental Health, Resilience and Emergency, and Adults and Health, other organisations represented include Public Health England, NHS Leeds CCGs, Leeds Teaching Hospitals, Leeds and York Partnership Foundation Trust, Leeds Community Health Trust, and NHS England. Each organisation has a responsibility and accountability for the City's health protection risks, the key performance indicators, regular updates are provided on key areas;
- Communicable Disease Control
 - Infection Prevention & Control
 - Environmental Health
 - Emergency Preparedness, Resilience and Response
 - Screening
 - Immunisation

2.4 In addition, the Board identified seven priorities in 2015 which required focused partnership activity to improve performance in Leeds. Subgroups were developed for each priority and progress reports to the Health Protection Board have been submitted and reviewed. The priorities identified in 2015 by the Board were:

- New migrant screening
- Tuberculosis
- Antimicrobial resistance
- Pandemic flu
- Seasonal death
- Air quality
- Surveillance

3 Main issues

Progress on priorities identified by the Health Protection Board (2015 – 17)

3.1 New migrant health screening

The Health Protection Board prioritised improving new migrant health screening focusing on TB, Hep B and C linking with HIV screening interventions. The main priorities include increasing awareness and improving access for new migrants across the health and social care system.

3.2 A number of interventions have been implemented to improve new migrant health screening:

Blood-Borne Virus (BBV) Screening in Primary Care Pilot (HIV, Hepatitis B and C):

The aim of this programme is to increase blood-borne virus screening, including the new migrant community, across Leeds. The Public Health Sexual Health Team in Leeds City Council was successful in their bid to obtain funding from the Elton John AIDS Foundation and Public Health England (PHE) to implement HIV screening in practices with estimated high HIV prevalence. This funding was supplemented by the three NHS Leeds Clinical Commissioning Groups (CCGs) in order to include hepatitis B and C screening, enabling it to be reframed as a Blood-Borne Virus (BBV) screening pilot. The pilot was launched on 20th November 2015 and ran for one year.

The pilot resulted in an increase in the number of people screened which directly resulted in the identification of new positive cases of HIV, hepatitis B and C. In total 3,748 people (18% of 20,615 eligible new patients) were screened for BBV, ranging from 0–67% of eligible new patients per practice. There were a total of 49 positive cases diagnosed in the first 12 months - 11 HIV, 30 HBV and 8 HCV. This represents a total yield of 13.1 per 1000 screens (2.9 per 1000 HIV tests, 8 per 1000 HBV tests and 2.1 per 1000 HCV tests).

Testing in participating practices increased by almost 250% compared to the year prior to the pilot. Cost per diagnosis is likely to represent significant savings to the health economy long-term. Phase 2 of the pilot is currently being rolled out within a smaller number of practices in the LS9 area and is due to commence in late August 2017.

Additional work has taken place to increase screening opportunities for new migrants from countries where there is a high incidence of TB. This is outlined in the next section.

The Health Protection Board has led discussions to improve migrant health in Leeds as a result from findings from a local Hepatitis A outbreak. In response to this, a report has been developed by local partners on migrant health, and is to be presented at the Health and Wellbeing Board in October 2017. The report recommends that Leeds requires a coordinated migrant health strategy to address the health needs of migrants in Leeds including health protection priorities. The report outlined significant health inequalities for migrants with regards to their access to health services and the burden of diseases including: Access to Primary Care; Mental health; Maternal Health; Health protection; Sexual health; Long term conditions; Substance use.

3.3 Reducing the incidence of Tuberculosis

Tuberculosis (TB) rates are declining both locally and nationally. Leeds Community Health Care TB service identified 92 active TB cases in Leeds in 2015 a reduction from 2014 (93 cases) however Leeds remains the second highest local authority area in Yorkshire and Humber¹ for TB. Leeds also had 120 cases of Latent TB Infection² (LTBI) in 2015.

The reduction in numbers of TB cases in Leeds in the past year has occurred in both the non-UK born population and the UK born population, although the incidence rates indicate that 69% of cases in 2015 were born abroad with 64% of those cases having lived in the UK for more than six years.

Despite the overall reduction in TB cases, the number of cases with treatment medication resistance and/or social risk factors (homelessness, drug or alcohol misuse or imprisonment) has not declined in keeping with the national picture. TB cases with social risk factors are more likely to have pulmonary disease and drug resistance, and have worse outcomes. In general the number of cases is reducing but the complexity of treatment and supporting social needs is increasing.

¹ Public Health England - Tuberculosis in Yorkshire and Humber: Annual review (2015 data) – March 2017. Table 1.1 Page 9.

² LTBI means a patient is infected with TB, but is not contagious or have any signs and symptoms.

A priority for the Health Protection Board has been Latent TB Infection (LTBI). Latent TB Infection means a person has been infected with TB but is not infectious and has no signs and symptoms. However, the identification and treatment of people with LTBI is an important part of managing the disease. The main risk of latent TB is that 10% of people go on to develop active TB.

The Health Protection Board has supported the following programmes focusing on identifying people with latent TB:

- NHS Leeds CCGs with support from LCC Public Health have been successful in attracting funding from NHS England to provide a targeted and enhanced screening and diagnosis service across Leeds for LTBI. The focus of the new LTBI Programmatic Screening Service is to deliver the three stages of a successful LTBI programme – access, testing and treatment. The city wide service identifies people registering at GP surgeries for the first time, who have visited or have moved from countries with high incidences of TB. This service has been in operation for one year and has screened an additional 92 people who meet the criteria for LTBI screening. An increased number of people have been found to be positive for LTBI and have been referred into services for treatment.
- In addition the LCC Health Protection Team has been working to raise awareness of LTBI to increase the numbers of people accessing screening and have pioneered a 'TB Champions' programme. The purpose of this programme is to train volunteers from the Third Sector to raise awareness of LTBI in under-served migrant populations. This innovative low cost/high impact approach is increasing awareness of active and LTBI, promoting the uptake of screening and treatment compliance. 47 TB Champions have been trained, 29 of whom are currently active. As of May 2017 they have spoken directly to over 500 people with cascade conversations across many hundreds more. A total of £1,326 from additional NHS England funding has been spent on this project during its first 6 month period which presents excellent value for money. This has been recognised as a model of good practice by Public Health England and is in the process of being rolled out across the region.
- Leeds has seen a number of highly complex active TB patients recently who have been diagnosed with drug resistant TB and who have no money, no housing and no recourse to public funds. These patients can be highly infectious and initially require hospitalisation followed by complex treatment on discharge back in the community. To enable a prompt discharge from hospital and community based treatment compliance Leeds City Council's Housing Options, Adults and Health, Leeds Teaching Hospitals and Leeds Community Health Trust have developed a new TB and housing pathway to enable

hospital discharge and community treatment planning with appropriate housing, relevant health and social care support.

The commissioning responsibility for the LCH Community TB Service was reviewed in light of the recommendations of the Health and Social Care Act 2012 and the national Collaborative TB strategy (2015), where TB commissioning of testing and treatment is stated as the responsibility of CCGs. In 2016 it was agreed by Leeds City Council and NHS Leeds CCGs to transfer the commissioning responsibility for the Leeds Community Health TB Service from Leeds City Council Public Health to NHS Leeds CCGs from April 2016, with associated funds. The transfer took place safely and effectively with no disruption to service delivery. LCH Community TB Service continues to deliver an excellent service with above average treatment completion rates.

3.4 Tackling antibiotic resistance

Antimicrobial resistance threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi. This is now a government priority as it is an increasingly serious threat to global public health. The UK government now has an Antimicrobial Resistance Strategy and Antimicrobial Resistance is now on the Department of Health's risk register. Action is required across all government sectors and society.

As a national example, of antimicrobial resistance, since 2003 there has been a sustained increase in the numbers of a relatively new and highly resistant infection called Carbapenemase Resistant Enterobacteriaceae (CPE). Identification of CPE in England by PHE has risen from fewer than 5 patients in 2006 to over 600 in 2013. Leeds so far, has only had a handful of positive cases compared to two Trusts in Manchester who have had more than 100 patients identified with CPE during the same period.

Antimicrobial stewardship is a national programme to take action to address drug resistant infections. Leeds is fortunate to have national leaders in tackling antibiotic resistance working in Leeds Teaching Hospitals, Public Health England, Leeds CCGs, Leeds University and LCC. Led by the Director of Public Health, these partners are working collaboratively and proactively to ensure that antimicrobial resistance is a priority locally.

Key achievements include:

- NHS Leeds CCGs with support from partners have been working to improve antibiotic prescribing practices of GPs and non-medical prescribers through regular education and training sessions. As a result the prescribing data collected locally indicates that the prescribing of broad spectrum antibiotics

has reduced to below the national target which is an important positive indicator for reducing the burden of drug resistant infections.

- Yorkshire and Humber Public Health England working with partners has developed and disseminated a local resource for GPs and non-medical prescribers outlining local resistance patterns to ensure effective prescribing.
- A local antibiotic campaign 'Seriously resistant' has been implemented by NHS Leeds CCGs and LCC targeting the general public. Specific campaigns have taken place in Leeds schools and universities to increase awareness in children and young people. This campaign has been very well received and has been replicated across the country. Insight work has been carried out to understand how effective these messages are and to establish the level of understanding of the public on this issue. The findings of this work will be used to inform future campaigns.
- As a result, Leeds was nominated for 5 awards in the UK Antibiotic Guardian awards event and were highly commended in 2 of the categories.

3.5 Health care associated infections

In Leeds, as in other areas, there is an ongoing challenge regarding Health Care Associated Infections (HCAI). The key HCAIs that present a potential risk to the health of the population are Meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C.diff). The NHS sets targets each year for the Clinical Commissioning Groups and for the acute Trusts. The target for MRSA is zero tolerance and C.diff thresholds are set each year by NHS England to reflect an improvement trajectory and therefore these relate to the previous year's performance.

It is required by the NHS that all cases of MRSA bacteraemia and C.diff cases undergo a root cause analysis to identify the cause and where a lapse of care may have occurred leading to the infection. This helps to inform future practice and ensure that identified learning is disseminated across the health care economy. In Leeds this process involves all stakeholders including Leeds City Council, Leeds Community Healthcare, Leeds Teaching Hospital, CCG's and primary care.

In 2016 a new forum, 'HCAI Improvement Group' was established within the city to address the challenges of HCAI's. Under the leadership of the Director Nursing and Quality for NHS Leeds CCGs, and with cross city representation, this group has made significant progress in improving cross system collaboration, improving quality through an enhanced root cause analysis process, post infection review process and improved communication across a complex system.

The key achievements since its formation in April 16 are:

- Significantly improved collaborative discussions, decisions and channels of communication;
- Consensus across the three CCGs for inclusion of closer GP involvement in HCAI investigation. This will be facilitated using the various GP engagement schemes;
- Progress toward an improvement in the accuracy of the mandatory reporting process for community associated CDI;
- Promotion of HCAI reporting in the CCG member practices to improve Datix reporting and significant event audit in Primary Care;
- Completion of a stock-take of relevant policies and guidance in relation to all providers;
- Progress toward improved review processes for the use of Protein Pump Inhibitors – a known risk factor for CDI;
- Development of a proposal for mutual aid arrangements to improve Infection Prevention resilience across the Leeds provider organisation.

3.5.1 Current position:

Clostridium difficile numbers have improved within Leeds since mandatory reporting by the NHS began in 2009. During 2016/17 Leeds Teaching Hospital, South and East CCG and North CCG achieved the nationally set NHS targets and overall the trend across the city is an improving one. A key priority for Leeds next year is to review and address the issue of CDI across the whole health economy to provide assurance that there is a robust system in place.

From April 16 – April 17 Leeds had 22 cases of MRSA bacteraemia. For comparison there were 13 cases in Leeds during 15/16, the number of cases in Leeds is higher than other areas with a similar demographic. Of the 22 cases 15 were identified as a lapse in care having taken place contributing to the infection. 7 other cases were successfully submitted to a panel at NHS England who agreed with the local investigation that no lapse in care had taken place. A number of these cases were associated with an outbreak of MRSA bacteraemia in people who inject drugs. Control measures were put in place by system leaders to identify potential cases within this vulnerable population and raise awareness amongst drug users of the risks and symptoms of MRSA. This was achieved through working in partnership with Forward Leeds, who provide services to drug and alcohol users within the city and others within the healthcare economy.

3.5.2 New and emerging health care associated infections:

There are new and emerging HCAI challenges for the Board to address in the coming years. There has been a sustained rise in Carbapenemase Resistant Enterobacteriaceae (CPE) infections in parts of the UK and it is essential that healthcare providers screen and isolate carriers effectively to prevent any spread within Leeds. The NHS has also implemented a new target to reduce the number of e coli blood stream infections by 10%. Leeds has an average of 45 blood stream infections caused by E coli per month and currently options are being considered as to how best to implement the new investigation process and enhanced learning across the system.

3.6 Infectious diseases incidents and outbreaks

Despite advances in the control and prevention of communicable diseases including vaccination programmes some infections still occur and require a public health response. During 2016 there were a number of incidents that required a routine response such as norovirus in a school or influenza within a care home. Systems are in place in Leeds to ensure these incidents are reported quickly and managed appropriately. These incidents have required a response from Leeds City Council in partnership with PHE and NHS providers.

The following sections highlight incidents that required partners to work together across the whole health economy to ensure the appropriate management of infection therefore protecting the health of the population:

- During April 2016 it was reported that a number of children visiting a local Leeds petting farm had become unwell with gastroenteritis. The outbreak involved individuals across four West Yorkshire local authorities (Leeds, Wakefield, Bradford and Kirklees) and two organisms, Cryptosporidium and E Coli O157. There were 33 confirmed, 11 probable and two secondary Cryptosporidium cases; and four confirmed, four probable and one secondary cases of E Coli O157. All those affected recovered well. The farm was found to have numerous failings relating to the unsafe operation of a petting farm and were served with a prohibition notice by Leeds City Council on the 20th April 2016. The farm was asked to cease operation which they did voluntarily and following this date no new illness was identified linked to the farm. The control measures put in place and the subsequent temporary closure of the farm protected the health of the population. The farm management were compliant with advice from Leeds City Council Environmental Health Team and made a number of improvements allowing the farm to re-open and no further issues relating to the health of visitors have occurred.
- In December of 2016 PHE notified LCC public health that three children in the same nursery, in Seacroft, may all have had invasive group A streptococcal infection (IGAS), only one case was confirmed however all became unwell

within the previous 3 weeks with similar symptoms, all 3 were in hospital. The transmission of IGAS within a nursery environment is not common however the consequences of IGAS can be significant. The public health response aims to prevent further transmission by offering prophylactic antibiotics to contacts which in this case would have been all the children in nursery. PHE made the decision that this was not required with 3 cases however if a 4th case came to light antibiotics would have been required. The Health Protection Team within Public health worked with the CCG's to ensure arrangements were in place and by Christmas Eve a robust plan was in place offering assurance that the out of hours health care economy could provide a response should it be required.

- In February 2017 there was an outbreak of viral gastroenteritis affecting diners who visited a restaurant in Garforth. By the end of the outbreak there had been 72 reports of illness from 40 different parties. The cause of this outbreak was almost certainly Norovirus. Outbreaks of Norovirus are common in environments such as care homes, hospitals, schools, nurseries, cruise ships, hotels and restaurants. There was significant interest in the outbreak locally on social media and from those who had become unwell. There was also some coverage in the local press. Due to the size of the outbreak a multiagency Outbreak Control Team (OCT) was put in place to coordinate the investigation, share intelligence and agree control measures, this was led by PHE. Representatives from Leeds City Council Environmental Health, Field Epidemiology Services (FES) Yorkshire and Humber, Leeds City Council Public Health, Leeds City Council Communicable Disease Control Nurses and the PHE regional microbiologist participated in the OCT. Leeds City Council Environmental Health Officers undertook a full inspection including sampling, an audit of food preparation processes and a check of staff members for infectious conditions. Some issues with surface hygiene were noted and the restaurant owners were instructed to carry out a deep clean of the premises. As a result of the inspection the food business was advised to review their procedures around cleaning and the reporting of illness by staff members. The hygiene rating for the restaurant was lowered from a 5 to a 3.
- From September 2015 to April 17 there were 48 cases of meningococcal meningitis in Leeds residents. Meningitis is a serious bacterial infection which can have devastating consequences for anyone who develops the infection. 23 were in adults and 16 were in the under 16's, sadly a small number of deaths were experienced in Leeds resulting from this devastating infection. This is consistent with the national picture. PHE manages the public health control measures for meningococcal infections and provided prophylactic antibiotics to the contacts of cases through NHS partners. Nationally the number of cases of meningococcal infection has reduced following the development and introduction of vaccinations against the different strains of meningococcal disease. In 2000 the Meningitis C vaccine was introduced to the UK schedule

and more recently in 2015 the Meningitis B vaccine was introduced as part of the primary vaccination schedule for children. Both of these initiatives have reduced the number of cases across the country therefore effectively protecting the health of the population.

- There was a large increase in the total number of influenza outbreaks reported to the PHE regional Health Protection Team in 2016/17³ compared to the previous flu season. In West Yorkshire, 25 outbreaks of influenza-like illness were reported in the 2016/17 season; 19 of these (76%) were in care homes.
- The LCC Health Protection Team, on behalf of the Board, has a responsibility to ensure new and emerging threats to health are considered. During the sustained outbreak of Ebola in West Africa from 2014-2016 the Leeds health economy via Public Health England implemented national plans to ensure those travelling from affected countries were screened according to national protocols and that the local NHS was informed of the potential threat. Plans were developed provide assurance that the NHS was able to respond if required. The plans for hospitalising and testing possible cases were implemented a number of times however no cases were identified within Leeds or surrounding area.

It is essential that Leeds City Council is able to respond to local, national and international incidents e.g. Zika virus that cause a real or potential threat to the health of the population. The threats from communicable disease are varied and unpredictable and strong local networks ensure information is shared quickly and appropriately therefore providing assurance that actions can be implemented to address future public health challenges.

3.7 Significant outbreaks and outbreak planning

3.7.1 Hepatitis A outbreak in a small community in Leeds

In July 2015 PHE Yorkshire and the Humber Centre reported a small number of Hepatitis A cases in LS9 postcode area of Leeds. This area was a close knit, deprived community with residents from a variety of ethnic and cultural backgrounds. By November 2015 a total of 18 confirmed cases have been recorded in the area. A multi-agency Outbreak Control Team (OCT) worked to identify, plan and implement control measures to manage the outbreak.

Once the cluster had been identified and community transmission confirmed a number of interventions were put in place to interrupt the outbreak cycle, this included:

³ Public Health England, Influenza and Respiratory Disease in Yorkshire and Humber Annual Report 2016/17 Influenza Season, June 2017

- A local community clinic commissioned from Leeds Community Healthcare (LCH) and delivered by their School Nursing Team resulted in 150 people being vaccinated.
- A GP “mop up” campaign over the following weeks vaccinated a further 50 people.
- Mobile hepatitis A vaccination clinic operated for one day in the outbreak area and a further 140 patients were immunised.
- In late October two local primary schools were identified as having evidence of transmission of the infection within the schools. LCH School Nursing Teams were commissioned to administer vaccines and over a five day period 1,120 staff and pupils from both schools were vaccinated. The implementation of this immunisation campaign necessitated the delay in the children’s school based influenza vaccination programme to 27 schools across Leeds.

The outbreak concluded in December 2016. A number of challenges and lessons learnt were identified by the Health Protection Board; steps have been put in place to strengthen local arrangements:

The Director of Public Health submitted evidence to the House of Commons Health Select Committee to highlight gaps in National policy on outbreak management. In the absence of national policy the Director of Public Health and Leeds Clinical Commissioning Group have agreed a draft set of principles to which the local system will develop a local outbreak management plan. The draft principles will be considered at the System Resilience Board for ratification later in the year.

Progress has been made locally to identify responsible commissioners for services to respond, how to mobilise those services, a process in which to operate a command and control system and pharmacy support to outbreak management.

A local operational outbreak plan will be finalised by the summer of 2017.

3.7.2 Avian Influenza cases

Following recent cases of avian influenza in North Yorkshire, Lincolnshire, Suffolk and Northumberland a request was made by both PHE and NHS E for each Local Authority area to provide assurance that an agreed protocol had been developed and agreed to provide antivirals to anyone who has been in close contact with the infected birds. A small task and finish group has been formed in Leeds comprising PHE, the Leeds CCGs (Urgent Care and Medicines Optimisation), and the Local Authority. The CCGs across West Yorkshire are in the process of agreeing a west Yorkshire Standard Operating Procedure with Local Care Direct to deliver the antiviral intervention. Meanwhile a response

flowchart has been developed locally to ensure an efficient response in the event of an incidence of AI in the Leeds locality.

3.7.3 Pandemic Flu planning

The risk of an outbreak of Pandemic Influenza remains high on the National Risk Register. The Local Authority has led on the development of an overarching Pandemic Influenza Plan for the city. The multi-agency Leeds Outbreak Planning Group has worked to develop and agree the plan which links the plans of each individual organisation across the city clearly outlining the roles and responsibilities of each organisation during a pandemic response.

The Leeds Outbreak Planning Group has expanded over the last year and currently comprises Resilience Managers and Infection Control staff from the three Leeds Health Trusts in addition to representatives from; LCC Children's Services, Public Health, Environmental Health and the Resilience and Emergencies Team, St Gemma's Hospice (on behalf of the three Leeds Hospices), Nuffield Leeds, HMP Leeds, the Leeds CCGs Urgent Care Team and Public Health England.

The over-arching Leeds Pandemic Influenza Response Plan was presented to the Leeds Health Protection Board in February 2016. The document was agreed in principle and now work continues in regard to: local Command and Control arrangements, access to Personal Protective Equipment and the inclusion of Third Sector support.

3.7.4 Leeds Outbreak Planning

The House of Commons Health Select Committee (HSC) met to consider the impact of the health and social care reforms on the public health system in 2016. The Director of Public Health submitted evidence to the Health Select Committee to highlight gaps in National policy on outbreak management.

In the absence of any national guidance, a local strategic outbreak planning roles and responsibilities group has been established, governed by the Health Protection Board. The group has considered a range of outbreak scenarios, applying a set of principles agreed between the DPH and Leeds North CCG Chief officer. The group has made good progress; they have agreed that outbreak management should operate under the Leeds EPRR system, making proposals based on the principles as to who pays, who the lead commissioners are, how to mobilise services and who the primary responding services are in the event of a specific outbreak. The intention is for this to be ratified later in 2017.

In addition, a draft Leeds outbreak plan has been developed. Once completed, the plan will need to be ratified by the System Resilience Assurance Board and the Health Protection Board.

3.8 Surveillance of infectious diseases across Leeds

The Health Protection Board has developed a streamlined process to inform system leaders of trends in infectious diseases and potential impact on local services.

A significant number of epidemiological reports are circulated across the system on a regular basis. The Health Protection Board identified that a systematic approach was required to ensure that data was being analysed and disseminated in a coordinated and efficient way.

Public Health England (PHE) produce and disseminate numerous reports on the majority of infections seen in the UK from common viruses such as norovirus to more complex bacterial diseases such as meningitis. They also collate data to indicate trends of disease such as influenza during the winter months. Some of the reporting is on a national basis however other data is produced using a more local footprint such as Yorkshire and Humber. The timing of the reports also varies greatly from weekly to annually.

Leeds Community Healthcare produce daily updates on how many care homes, schools and nurseries have restrictions in place due to gastroenteritis in Leeds and Leeds Teaching Hospital Trust produce daily updates on the number of wards closed due to various infections most commonly gastroenteritis.

In order to ensure system leaders within the healthcare economy are aware of current issues in Leeds a weekly update report has been introduced which summarises the key points from the numerous surveillance reports received. The report offers a snap shot of the current infections circulating within the city such as influenza and norovirus. It also ensures individual cases of infection, such as a death due to meningitis are highlighted.

The system has been in operation for 12 months and has ensured that any concerns around trends of diseases within the city are highlighted and acted upon in a timely fashion to reduce the impact of infections across the system.

3.9 Tackling seasonal deaths

In Leeds, as in the rest of the country, more people die in the winter than in the summer. Many of these deaths are avoidable and are primarily due to heart and lung conditions rather than hypothermia. There has been cross organisational

efforts to address the negative impacts of cold weather in Leeds, work programmes are well established and embedded in services to protect the most vulnerable in the city. Modelled figures show that Leeds has seen a decrease in numbers of people dying from the effects of living in cold conditions, with a reduction in excess winter deaths to 350 in 2015/16 compared to 470 deaths in 2014/15.

NICE guidance (2015) states that fuel poverty, poor housing and health inequalities significantly increase illnesses over winter – which adds to the pressures on health and social care services. Since the Department of Health first published its Cold Weather Plan in 2011, and more recently the NICE guidance on excess winter deaths and morbidity, Leeds has responded by developing and implementing a local plan. The plan aimed to firstly raise the public's awareness of the harm to health from cold and secondly to provide support to the most vulnerable.

The Health Protection Board has made significant progress towards reducing seasonal deaths:

- *Met Office alerts*: The development of a systematic approach to cascading the Met Office alerts across health & social care. This enables health & social care workers to identify and support vulnerable people; this has been audited to ensure that alerts are reaching frontline workers who are providing direct care to vulnerable people. More work needs to be done to ensure that dedicated programmes reach the people who most need support.
- *Warmth for Wellbeing Service*: A jointly commissioned service between Public Health and Clinical Commissioning Groups (North and South & East), delivered by Groundwork Leeds in partnership with Care & Repair. This is in addition to the Council's Sustainable Energy & Climate Change (SECC) funding. Based on 2016 data, the Service exceeded their annual target of 1150 visits by 34 visits. Since the contract started on the 1st of October 2015, 1865 clients have been visited with at least 3,500 beneficiaries (as on average there are two people per household). The Service is receiving excellent feedback from clients and referral agencies.
- *Warm Well Homes*: LCC Public Health supported the successful "Warm Well Homes" bid by the LCC Sustainable Energy and Climate Change team, which levered in an additional £280K to provide heating and insulation, to help make properties of vulnerable households warmer. Referrals will be managed by the Warmth for Wellbeing Service;

- *Winter Wellbeing Small Grants Scheme*: For the 5th consecutive year, LCC Public Health has commissioned Leeds Community Foundation (LCF) to deliver a Winter Wellbeing small grants scheme. Funded projects included befriending, Winter Wellbeing cafes, essential winter wellbeing items, arts and craft skills, community transport and exercise classes. It demonstrated how the grants scheme relates to a number of priorities: hospital avoidance, social isolation, (fuel) poverty, mental health and resilience, physical activity and nutrition.
- *CAB and Welfare Rights advice in Primary*: Public Health continued to fund CAB and Welfare Rights advice in Primary Care (GP practices, Health Centres) and Mental Health (inpatient wards, day centres) which contributes towards income maximisation and CAB also help clients with utility enquiries. NHS Leeds CCGs social prescribing schemes support clients with their housing needs, which include those suffering from fuel poverty. The scheme works to promote self-care and winter wellbeing including appropriate use of NHS services, flu jabs, keeping warm at home, mental wellbeing, and support for vulnerable people.
- *Winter Friends programme*: The programme, led by LCC Public Health, helps vulnerable residents to live independently by informing them about social activities and important services that will help them 'Stay Well this Winter'. The Network has expanded to 70 groups and organisations across the statutory sector and has demonstrated tangible outcomes for vulnerable people.
- Finally, the NHS Winter Plan (2017) will include the preventative elements of winter planning and hospital avoidance and will provide an opportunity to further embed the above programmes in health and social care services, providing greater reach to vulnerable people.

3.10 Increasing Seasonal Flu vaccination uptake

A factor in seasonal deaths and a demand for health and social services is seasonal influenza, which is an acute highly infectious viral infection of the respiratory tract and is highly infectious. It is important that every effort is made to reduce the rate of infection and prevent the spread of the virus.

The seasonal flu campaign targets those 'under 65' years and at clinical risk e.g. chronic health conditions, those immunosuppressed. The risk of serious illness from influenza is higher amongst children under six months of age, older people, and those with underlying health conditions such as respiratory disease, cardiac disease, and pregnant women.

The national target set by the World Health Organisation for over 65s influenza immunisation campaign is 75%. In previous years Leeds has met this target, however in the 16/17 period, Leeds has experienced a slight drop in uptake in all three CCG areas. In the Leeds North CCG area the uptake was 75.3%, down from 75.7% in 2015/16, but still meeting the national target. Whilst in Leeds West and South and East CCG areas uptake fell just short of the target at 72.3% and 74.8% respectively, both down from previous years. All areas' uptake rates are slightly down from last year in this target group.

There has been a steady increase in the uptake rate of the under 65 age group who have a clinical risks in the last 2 years. More work needs to be done to increase uptake in this group and NHSE have a number of programmes in place to address this.

Although GP practices are primarily responsible for offering the vaccine to their eligible patients in 16/17, NHS England has been working with Community Pharmacy West Yorkshire to commission pharmacies to deliver to over 65s, at risk patients and pregnant women to increase uptake and offer more patient choice. Pharmacies delivered over 9,200 vaccinations across the 3 CCG areas in 16/17, including for those who'd never previously had flu vaccination.

In the local health care provider organisations there has been a year on year steady increase in uptake amongst staff groups. Leeds Community Health Trust (LCH) Infection Control Team achieved 77% uptake in the LCH Staff Flu Campaign achieving the lead community trust in the Country, the trust was nominated for 3 Awards nationally. Their work was presented to NICE and at National and Local conferences sharing best practice. Leeds Teaching Hospitals also achieved their highest uptake rate in reaching 80% coverage in their staff groups. Leeds and York Partnership NHS Foundation Trust increased on their previous year's uptake reaching 55% coverage.

Leeds Community Healthcare School Immunisation Team provide the school immunisation programme, they offered 100% of all children in Years 1, 2 and 3 attending a Leeds School the nasal flu application. The uptake for the application was 52%.

The Health Protection Board has discussed concerns around the extension of the eligibility criteria for the upcoming flu season and ability of services to deliver. The extension will include Reception and Year 4 children, this will be a collective cohort of 52,000 children. Options are being developed to identify how services would be able to respond to the increased number of children requiring this vaccine.

Work has already commenced between Health Protection Board partners for the 2017/18 seasonal flu vaccination programme including the development of a communication plan for social media (Twitter & Facebook), engagement with the care home sector, promoting staff uptake, improving data reporting systems and strengthening the role of pharmacists.

3.11 Air Quality

Air pollution is now associated with much greater public health risk than was understood even a decade ago, and more associated adverse health effects are emerging. As such, air pollution in the UK is now regarded as the largest environmental risk linked to deaths every year and yet it is evident that general public awareness of the impacts of poor air quality on their health is lower compared to other health issues such as smoking or obesity.

For Leeds, an estimated 4.3% of all-cause mortality is attributable to air pollution. However, the impact is better understood in terms of lifetime lost to the population, currently estimated at around 6 months on average for each person in the UK. It is not known how this effect is distributed across the population, although much of the impact is linked with cardiovascular deaths, and it is likely that air pollution places an additional burden on many people, being a contributory factor in bringing deaths forward, rather than being the sole cause of death for individuals.

On behalf of the Health Protection Board the LCC Health Protection Team has worked to understand the current Leeds status of air quality and has proactively engaged with a number of partners to ensure that health protection is a principle aim of the Leeds City Council Clear Air Action Plan and is able to effectively influence the air quality agenda at a local and regional level.

Whilst there are complexities surrounding the health impacts of various air pollutants, the associated health messages and communication mechanisms should remain simple. By having a simple means of gathering clear information of the effects of air pollution in the local population, this will help empower people to make informed decisions on how to reduce exposure and if required, to better manage their health conditions.

Linked to this particular enabling factor around improved promotion and profile, it is vital that we do achieve a greater level of acceptance so that actions and understanding go hand in hand. It is important that we inspire people to change and to do that, we also need the innovation for alternative choices as well as the infrastructures in place to aid behaviour change. These enabling factors are set out within the Leeds Clean Air Action Plan.

Following the recent publication of the updated Clean Air Zone Framework, there is a need to consider the implications of this and in particular, to assess how this new framework will now be informing local preparations for the introduction of a Clean Air Zone.

3.12 Large city events and health protection planning

Over the last year Leeds City Council has established the Leeds Safety Advisory Group (SAG), this group is co-ordinated by the Local Authority (LA) and made up of representatives from the LA and emergency services. The role of the SAG is to advise, and ultimately take a lead in ensuring the safety of all events held in the Leeds area. The process involves the completion of a risk scoring matrix where events can be graded at low, medium or high risk. The SAG, as an advisory body that provides feedback to organisers in regard to their event plans. The Group is made up of 60+ professional people with event organising specialisms from different organisations (blue light, licensing, highways, health and safety, adults and health, emergency planning etc). In addition there is a new portal on the LCC website for event organisers to access to take advantage of the SAG process. (<http://www.leeds.gov.uk/leisure/Pages/Organising-Events.aspx>).

The Leeds Health & Social Care Resilience Group provides a forum for event information to be shared between health and social care partners and for concerns to be raised and fed back to the Safety Advisory Group. Issues can then be managed either through Council Directorates or passed back to the event organisers to be addressed. The criteria adopted by the group to ensure the safe delivery of health and social care services are listed below:

- maintaining blue light\emergency routes
- maintaining access to Leeds General Infirmary
- access to clients for social care
- access to day centres
- access for meals at home and the equipment service
- communication to staff, both NHS, ASC and Commissioned Services
- information shared with hospitals, nursing homes, day centres
- health advice and communication to the general public

The SAG has played an instrumental role in ensuring the safety of the public in recent local events including the Tour de France in 2015 and the World Triathlon in 2016. The SAG ensured that the requirements of Health and Social Care providers were considered as a priority by all Council Directorates involved in the delivery of these events across the city. The learning from these events has been incorporated into the planning for future events including the 2017 World Series Triathlon.

The Emergency Planning Officer for Health Protection also attends planning meetings for the Leeds Half Marathon, 10K and the Leeds Carnival to ensure the above criteria are met throughout the planning process.

3.13 Screening programmes

NHS England West Yorkshire Screening and Immunisation Service is responsible for the commissioning of screening programmes nationally under the Public Health Functions Agreement (Section 7A).

Progress on performance is considered at the Health Protection Board for the following screening programmes cervical, breast, bowel, AAA (Abdominal Aortic Aneurysm), diabetic retinopathy, new born blood spot, ante-natal infectious diseases, Down's syndrome, Thalassaemia, sickle cell, new born hearing.

For the purpose of this report three areas of concern are highlighted – cervical, breast, cancer screening.

Women attending for cervical screening in Leeds is declining and this reflects the position across England. Against the uptake target of 80%, Leeds has slipped from just under 80% to around 75%. Breast cancer screening uptake too has fallen although each CCG is still just above the minimum standard of 70%. Again, this mirrors the national position where screening uptake has fallen for the third year running.

NHS England has established a Leeds plan to improve coverage. There is a particular focus on addressing inequalities in terms of access of defined at risk groups (more needed)

The bowel screening programme meets the National Service specification target of 52%. The priority for the Health Protection Board has been to extend the ages covered by the programme. Previous operational difficulties were overcome by commissioners and providers so that the programme age was extended in January 2015. Work will continue to meet the NHS England aspirational target of 60% uptake.

3.14 Health Protection Priorities for 2017-2020

The Health Protection Board discussed and reviewed the priorities identified by the Board in 2015 at the May 2017 Board meeting.

The Board identified that good progress had been made in all priority areas identified in 2015; this is a positive step forward for health protection in Leeds. The Board recommended that as a result, two of the priorities; new migrant case finding and improving surveillance, could be closed from the priorities list, due to good progress made.

In addition, the Board recommended two new priorities to be added. This was due to increased levels of risks associated with these areas locally. They are reducing the incidence of health care associated infections and agreeing roles and responsibilities and developing a local plan for outbreak management in Leeds.

Health Protection Board priorities for 2017-2020:

- Tackling antibiotic resistance.
- Addressing air quality and impact on health.
- Reducing seasonal deaths from severe temperatures.
- Reducing the incidence of TB.
- The development of an outbreak plan for Leeds
- To reduce the incidence of health care associated infections across the Leeds

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

- 4.1.1 This report has been developed in collaboration with the members of the Health Protection Board including NHS England, Public Health England, LTHT, Leeds Community Health Care, Leeds and York Partnerships Trust, Leeds City Council, Leeds CCGs. All organisations consult and engage with the affected population groups.

4.2 Equality and diversity / cohesion and integration

- 4.2.1 While there are no direct Equality/Diversity/Cohesion or integration implications of this paper, all organisations concerned are actively involved in work in this area, and the raising of the standard of quality care in the city contributes directly to access and equality issues.

4.3 Resources and value for money

- 4.3.1 There are no direct resources/value for money implications arising from this paper.

4.4 Legal Implications, access to information and call in

- 4.4.1 There are no legal or access to information implications of this report. It is not subject to call in.

4.5 Risk management

- 4.5.1 A robust evidence base is vitally important in ensuring our collective approach to tackling health and wellbeing inequalities. We aim to ensure that we continually strengthen our approach to understanding the health protection risks in Leeds; this process is managed through the Health Protection Board.

5 Conclusions

- 5.1 This paper provides the Health and Wellbeing Board with the second annual report of the progress of the Health Protection Board since it was established in June 2014.
- 5.2 The Health Protection Board has made good progress on all priority areas. It recently reviewed the priorities and recommended that two of the priorities, new migrant case finding and improving surveillance, were closed from the priorities list due to good progress made.
- 5.3 In addition, the Board recommended that reducing the incidence of health care associated infections, and agreeing a local plan for outbreak management in Leeds should be new priorities for the Board.
- 5.4 The Health Protection Board has been assured to date that robust arrangements are in place to protect the health of communities. It will continue to ensure that Leeds has robust arrangements in place to protect the public from health protection threats.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the Health Protection Board's Annual report.
- Note the key progress made against the priorities identified in the Health Protection Board Annual report 2014/15.
- Note the new priorities identified by the Health Protection Board for 2017/20.

7 Background documents

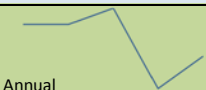
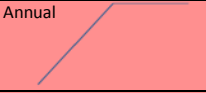
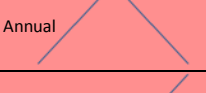
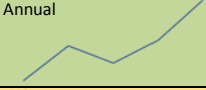
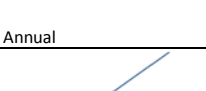
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Headline Health Protection Indicators Annual Report 2016-17

Key Health Protection Indicators for Leeds from the Public Health Outcomes Framework

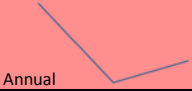
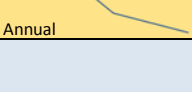
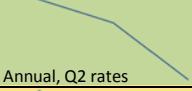
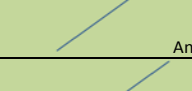
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Air Quality		National Figure/ Target	Most recent Leeds Figure	Trend & RAG rating	Improving / Level / Worsening
Air quality annual average PM10 Air concentration at (worse performing site in Leeds)		40 µg/m3 annual mean objective not to be exceeded and reducing trend	(2016) 19 ug/m3	 Annual	Improving
Air quality annual average PM 2.5 concentration		To meet WHO air quality guideline of 10 µg/m3 and reducing trend	(2016) 10 ug/m3	 Annual	Improving
Healthcare associated infections					
Zero tolerance for MRSA bacteraemia cases	NCCG	0	1 (2016-17)	 Annual	Level, (zeros & 1s)
	WCCG		2 (2016-17)	 Annual	Improving
	SECCG		2 (2016-17)	 Annual	Level, (2,3,2)
	LTHT		11 (2016-17)	 Annual	Worsening
Incidence of healthcare associated infection: C Difficile	NCCG	58 per annum	16 (Q4 2016-17)	 Qtrly	Level
	WCCG	90 per annum	28 (Q4 2016-17)	 Qtrly	
	SECCG	104 per annum	19 (Q4 2016-17)	 Qtrly	Improving
	LTHT	119 per annum 2015-16	34 (Q4 2016-17)	 Qtrly	
Tuberculosis					
Treatment completion for TB		85%	91% (2014)	 Annual	Improving
TB rate per 100,000 (Uses 2013 population as denominator between 2009 and 2013. 2014 and 2015 data use matching denominator years)		Decrease current rate	12.0 / 100,000 (2015/16)	 Annual	Improving
Reduce deaths in Leeds caused by TB		Zero deaths	2 (2014)	 Annual	Improving, numbers near to zero
New active TB cases		no target set	76 (Jan-6th Dec 2016)	 Annual	Improving
Multi-drug resistant TB cases (MDR)			2 (Jan-6th Dec 2016)	 Annual	Level
LTBi (Latent TB infection) cases			170 (Jan-6th Dec 2016)	 Annual	Worsening

Headline Health Protection Indicators Annual Report 2016-17

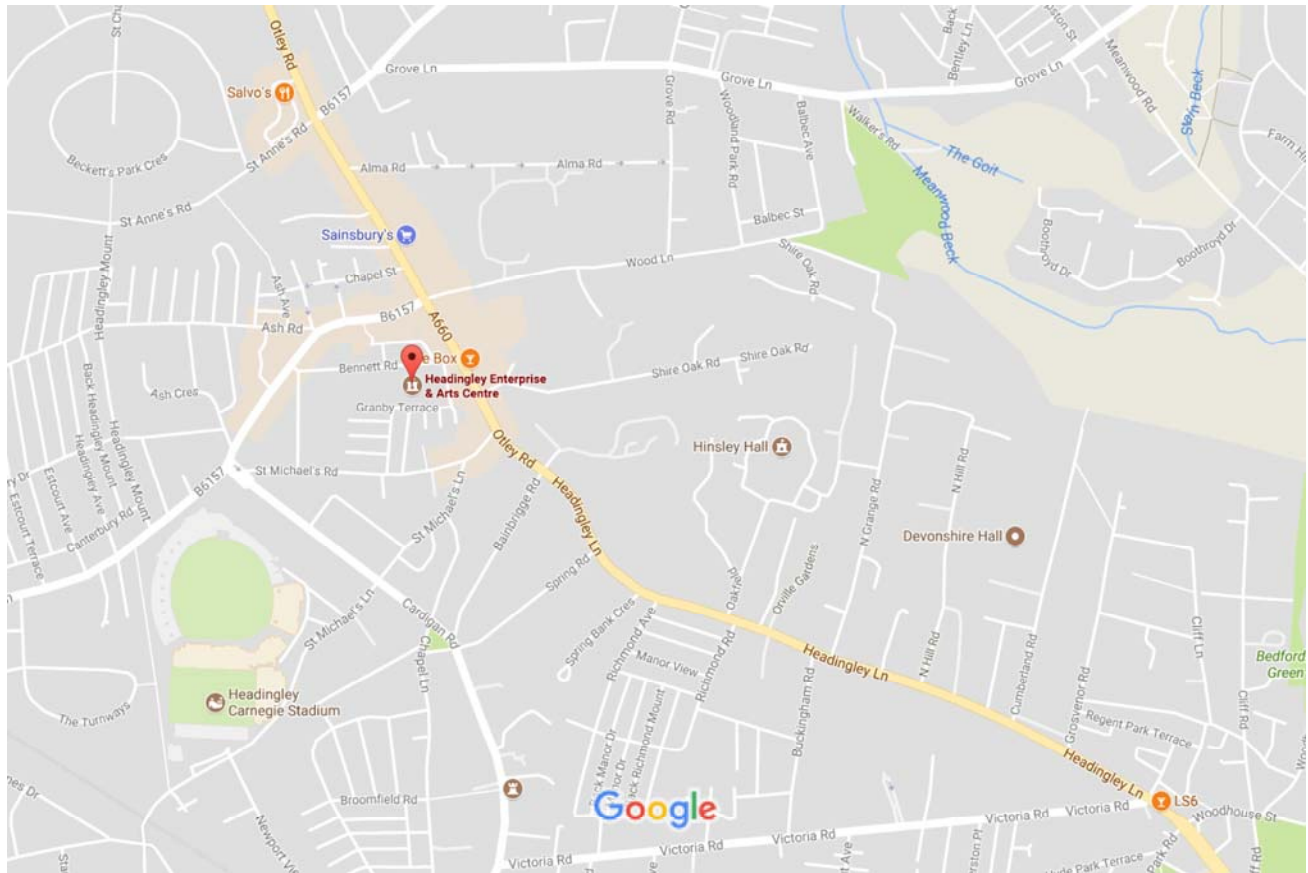
Key Health Protection Indicators for Leeds from the Public Health Outcomes Framework

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Influenza		National Figure/ Target	Most recent Leeds Figure	Trend & RAG rating	Improving / Level / Worsening
To increase uptake of influenza programme under 65 years clinical at risk groups	NCCG	no target set	50.6% (Sep16 - Jan17)	 Annual	Worsening in line with national trend
	WCCG		34.3% (Sep16 - Jan17)	 Annual	
	SECCG		49.6% (Sep16 - Jan17)	 Annual	
Achieve WHO vaccine uptake for over 65 years influenza immunisation	NCCG	75% WHO	75.3% (Sep16 - Jan17)	 Annual	Worsening but meeting target
	WCCG		72.3% (Sep16 - Jan17)	 Annual	Worsening trend but just below target
	SECCG		74.8% (Sep16 - Jan17)	 Annual	
Vaccinations and Immunisations					
MMR Uptake of two doses (completion of first and second dose at 5 years)		86% PHOF	88.4% (Q2 2016-17)	 Annual, Q2 rates	Worsening but above PHOF indicator
Cervical Screening - % of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period	Leeds	80% 75.3% PHOF	74.1% (2015-16)	 Annual	Worsening very slowly in line with national trends
Breast cancer screening coverage - % of eligible women 53-70 screened adequately within the previous 3 years on 31st March.	Leeds	76.9% coverage aged 53-70 in 2012. 70% minimum	72.3% (2014-15)	 Annual	
Bowel cancer screening 60-74. Uptake. (% of adequately screened for invites sent within quarter - all subjects episodes)	NCCG	55.8% PHOF Aspirational local target of 60%	58.8% (2015/16)	 Annual	Improving
	WCCG		58.4% (2015/16)	 Annual	
			SECCG		53.9% (2015/16)
Emergency planning			Notes		
Ensure that all Cat 1&2 organisations have plans/procedures in place to respond to our top risks		Leeds pandemic plan agreed 2016 Leeds outbreak plan draft for completion in 2017			
Ensure exercises have taken place to validate emergency plans and organisations have incorporated any learning		Leeds City Council exercises: Precious Metals – February 2016. Day Hawk – Oct 2016. Pandemic Influenza – Spring 2017. World Triathlon – table top exercise to take place 2016\2017 West Yorkshire Exercises: Linus – February 2016. Leyland – March 2016 Local Exercises: LTHT CBRN – Operation Jenny – June 2016			



Headingley Enterprise & Arts Centre, Bennett Road, Leeds LS6 3HN



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