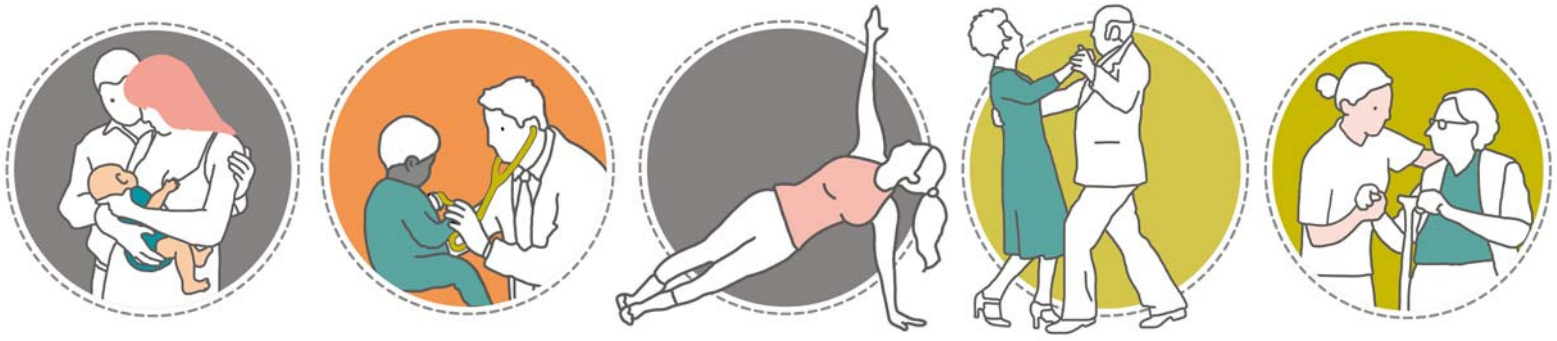
Leeds

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

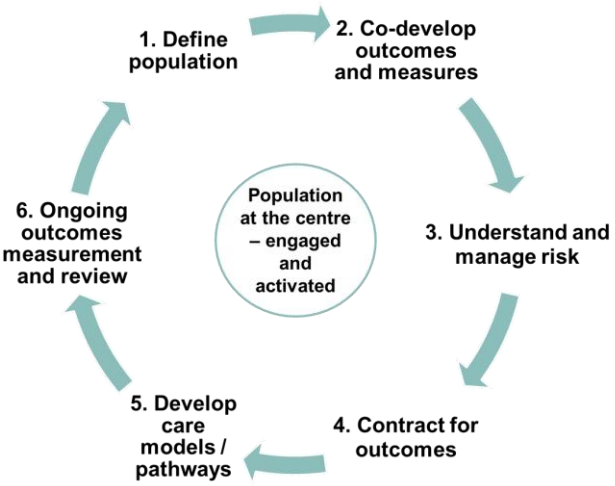
Work has been undertaken with teams across Leeds to scope and propose solutions to each of these four challenges. These are described in detail in the Blueprint and are summarised in the section below:

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.

Figure ES1 – A System Approach to Population Health Management



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.

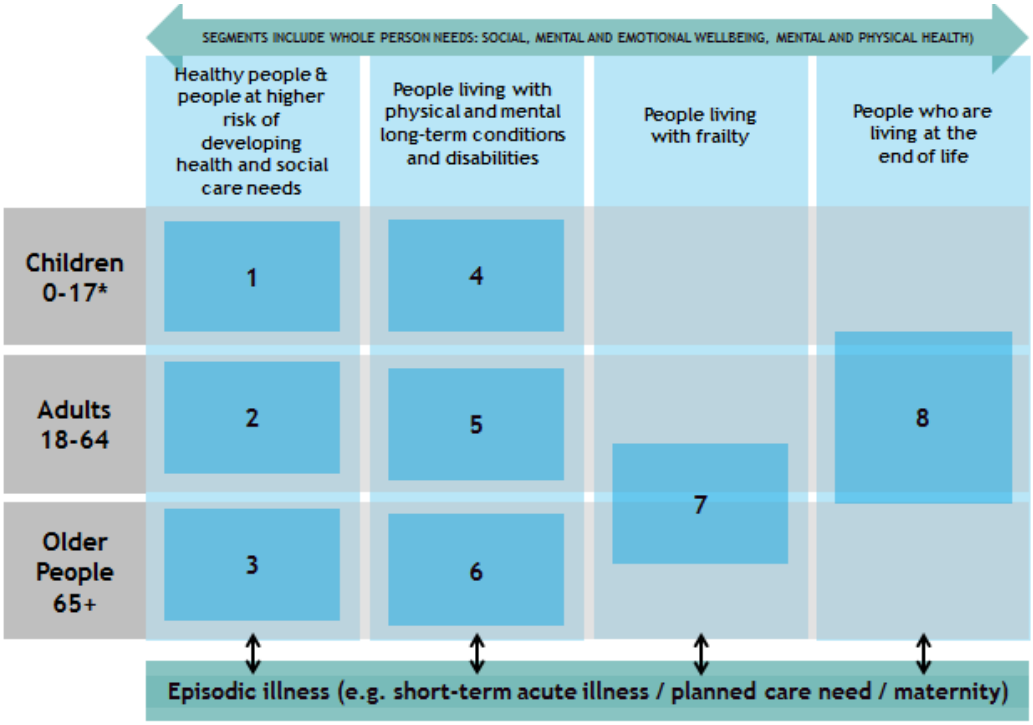
However, as this is a new and complex approach, this Blueprint recommends a pragmatic approach of starting with one population grouping or 'segment' and developing learning (e.g. around analysis, setting of outcomes and development of new payment systems and contracts) at pace before moving onto the 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 ***(N.B. Services or conditions will need to be translated into a macro population segment)***	
#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.	

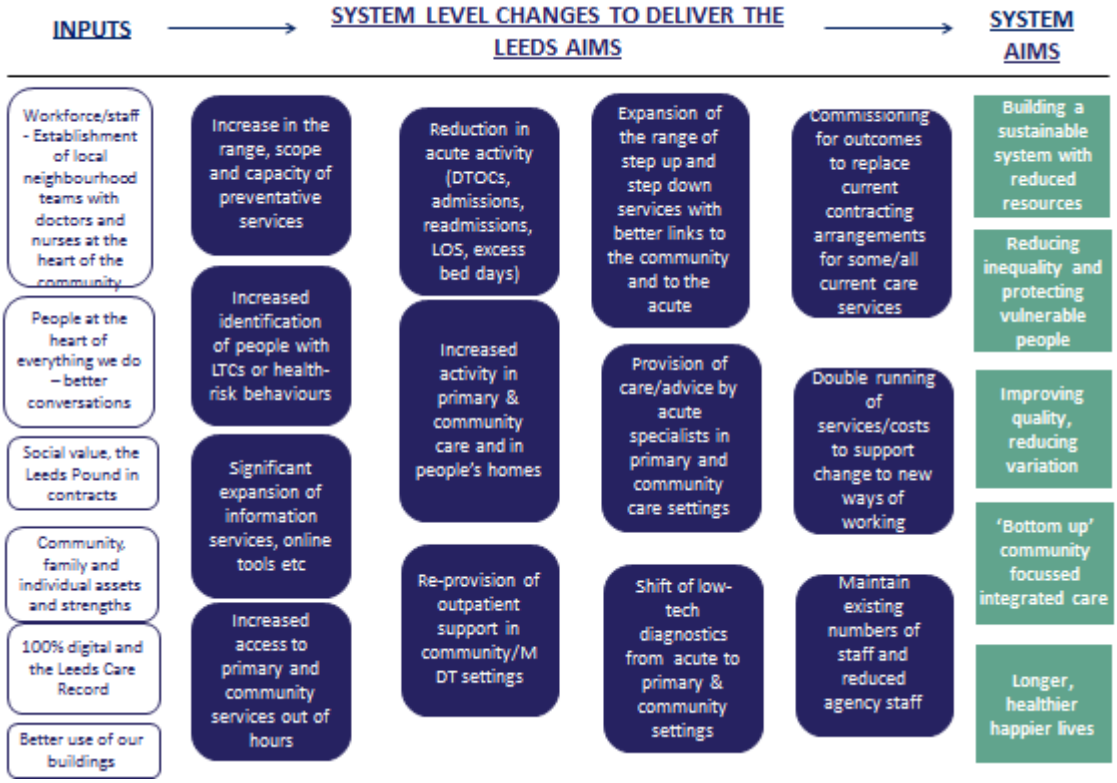
Challenge 2: System Level Changes

- 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

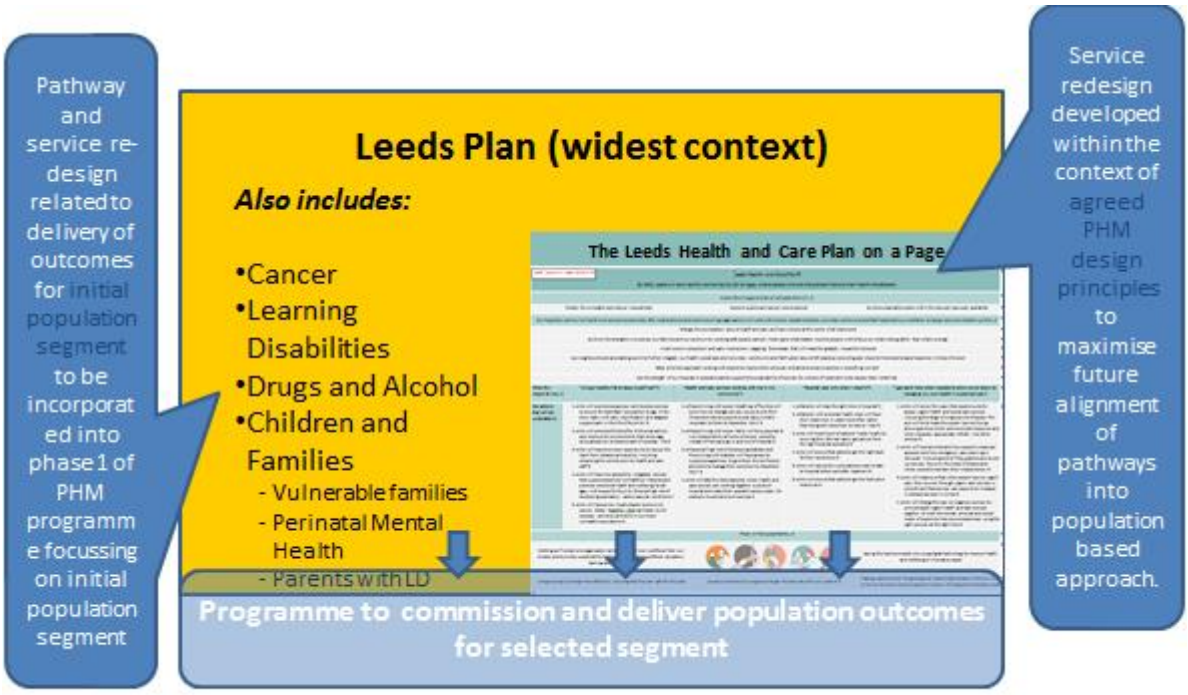
- Through the System Alignment process, leaders from across the system articulated that neither the vision nor the three gaps/'triple aim' in the Leeds Plan are deliverable without system transformation.
- The current workstreams within the Leeds Plan are changing to understand how they deliver against 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.

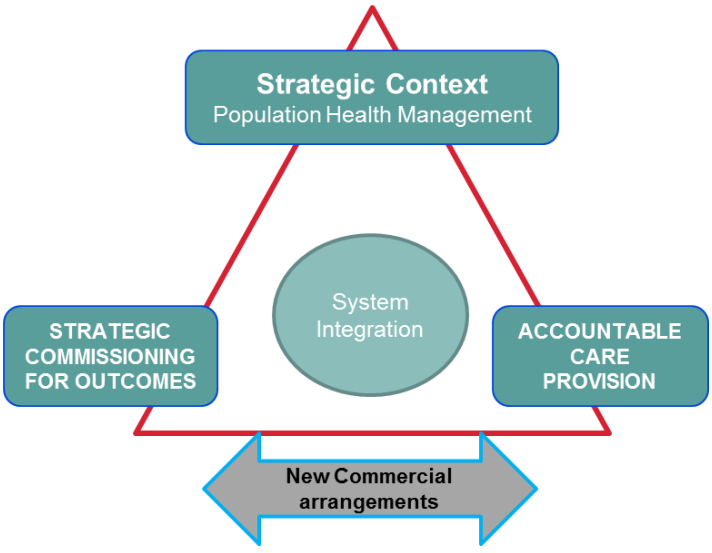
1.2 Population Health Management

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 (LTHT) 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 LTHT 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:

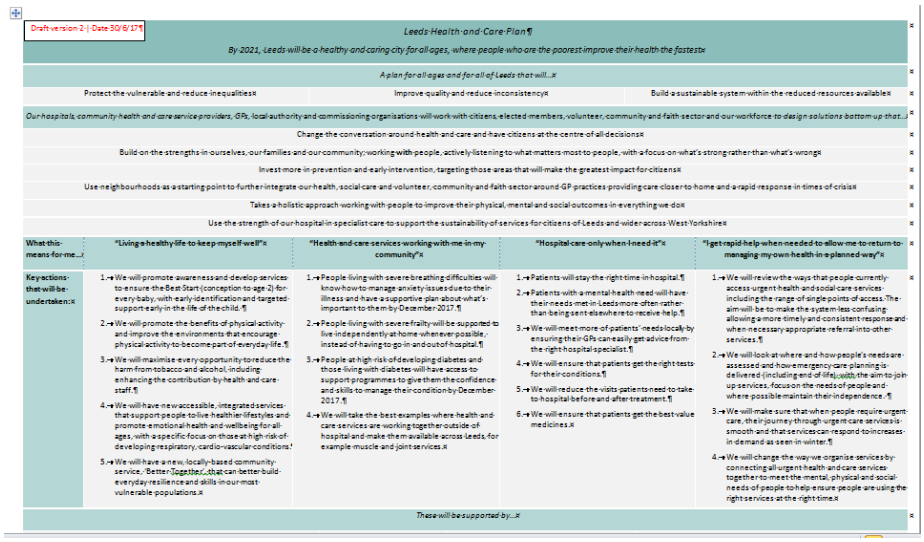
1. Health and wellbeing
2. Care and quality
3. Funding and efficiency.

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.

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		

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



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.

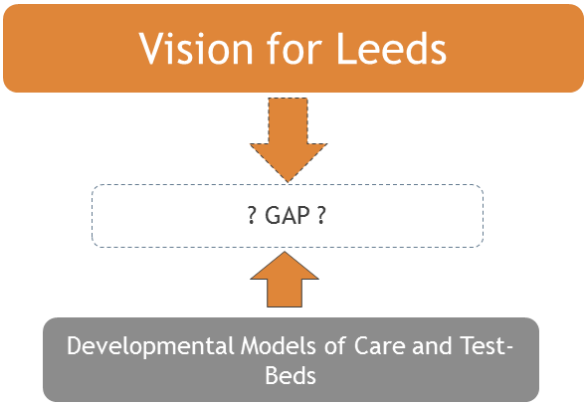
However, achieving material impact across the city through scaling up these test beds remains a challenge. In addition, it is vital that, in future, initiatives are developed and delivered consistently with the principles of system working, integrated provision and outcome based commissioning and through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

Figure 3 – The gap between the vision and the current actions



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.

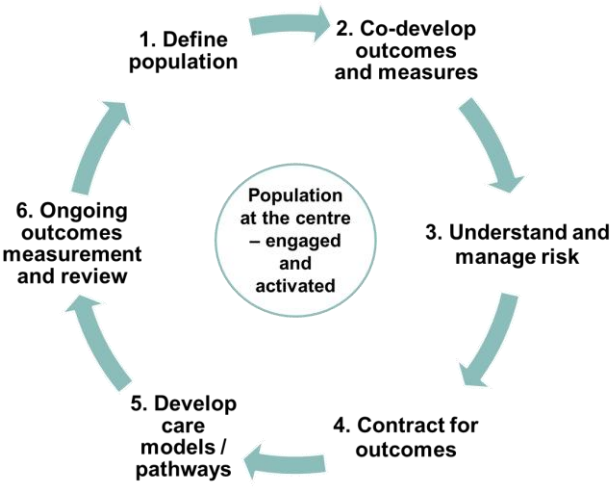
3 – Challenge 1 - Rapid Progress with Population Health Management (PHM)

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.

Figure 4 – A System Approach to Population Health Management



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.

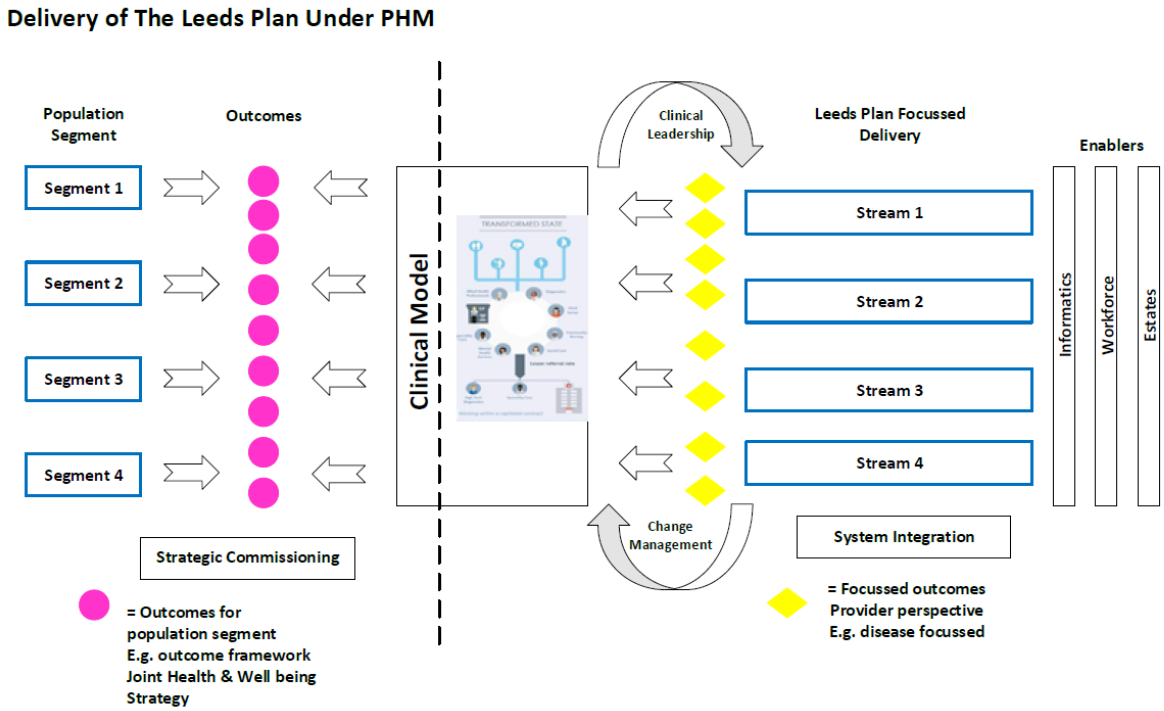
This Blueprint proposes a combined 'twin approach' to take forwards PHM: harnessing the positive energy of existing progress on the ground, but aligning this to a much stronger, system-led direction of travel.

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:	**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.	• **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 towards integration, alignment of priorities and incentives, joint working and exploring shared risk.

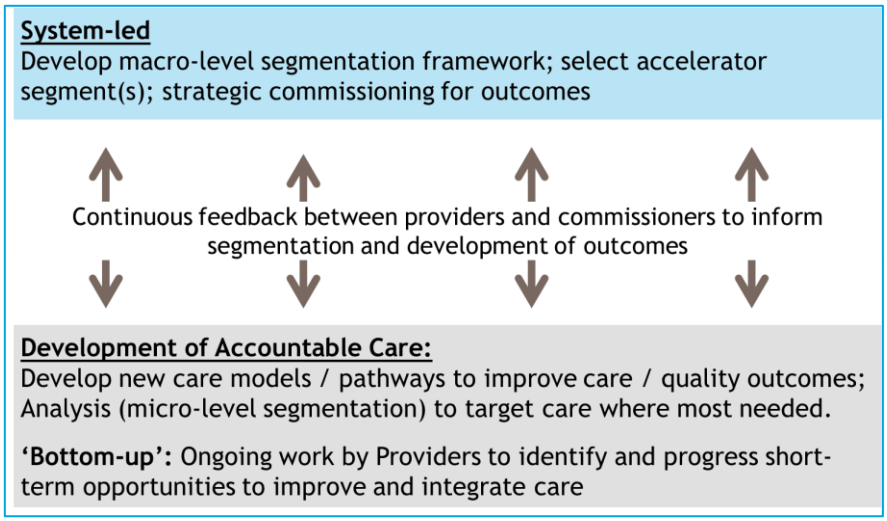
Figure 5 – Summary of Strategic Commissioner and System Integration Roles in PHM



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.

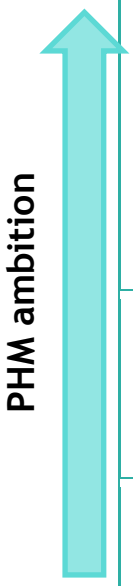
3.3.1 Population Segmentation Workstream

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.

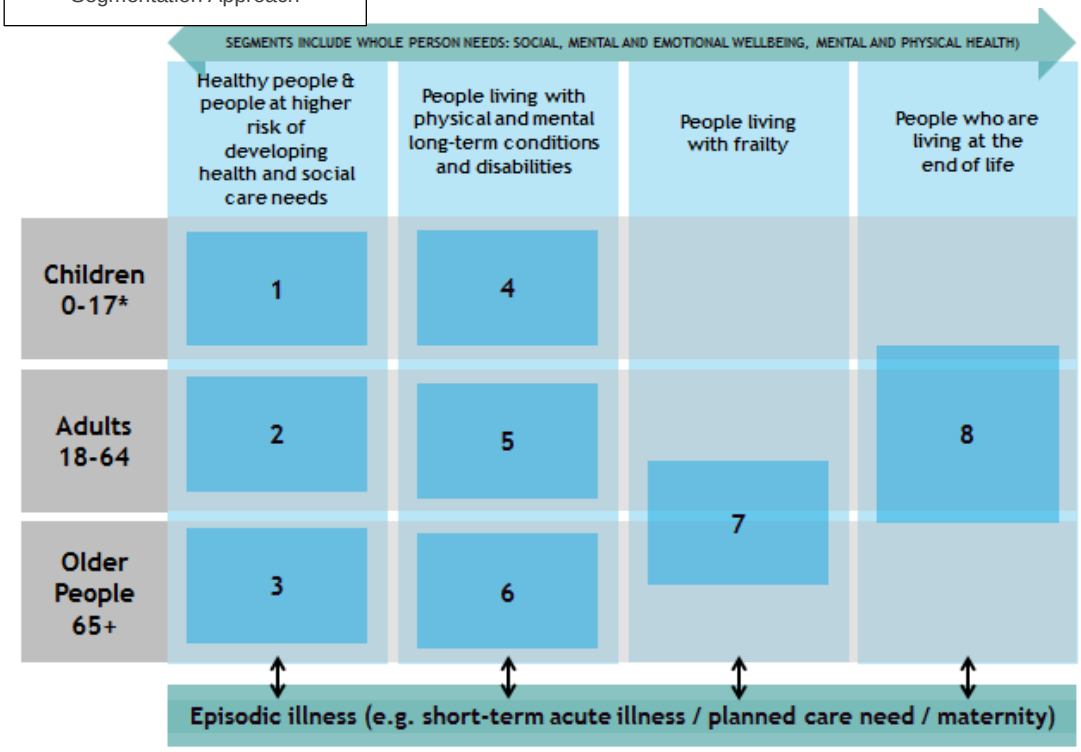
Leeds is also keen to maintain progress at a 'meso' and 'micro' sub-segment level, as per Approach 2 as described in section 3.2.1. As stated throughout this document, there is a lot of good work underway to integrate care and improve pathways for people with multiple needs, e.g. the new model of care 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 ***(N.B. Services or conditions will need to be translated into a macro population segment)***	
#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.

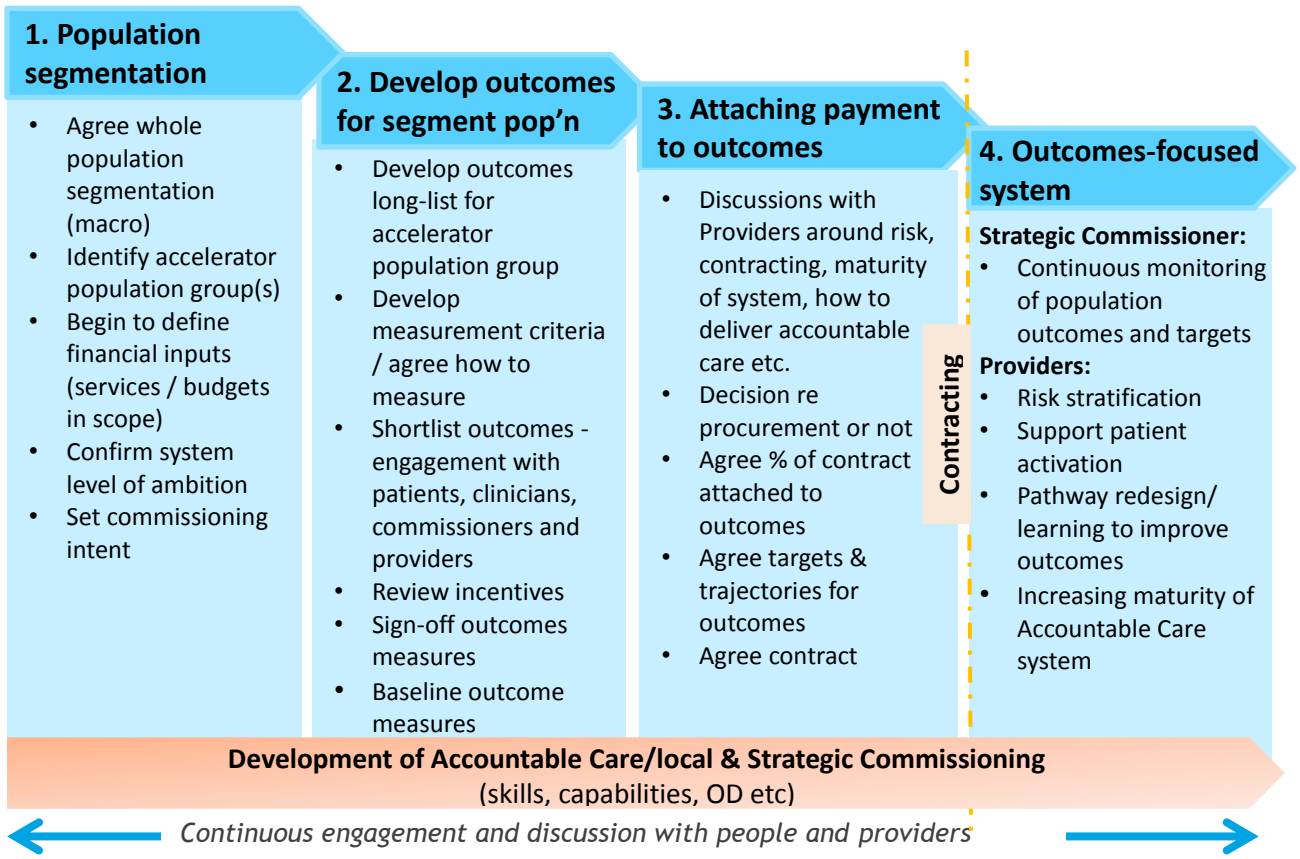
- To put in place live contracts for the initial accelerator population segment/s by **April 2019** (see Finance and Contracting section in Chapter 6). This represents a commitment to move at pace, although this speed will be dependent on the level of collaboration between and with Providers and the 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 heath 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 ad 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.

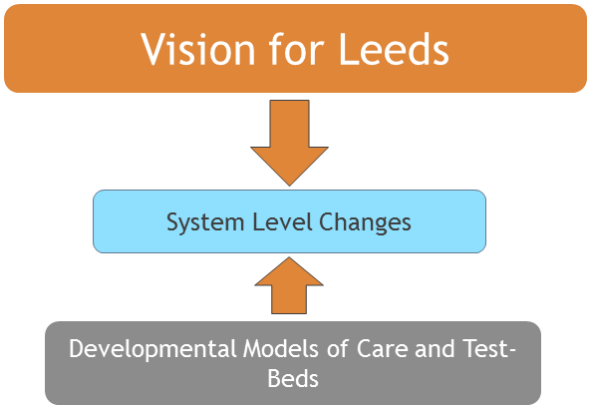
As stated above and highlighted during the system alignment process, there is a clear need to clarify how the range of activities being undertaken on the ground (e.g. Leeds plan workstreams, New Models of Care test beds etc) will help to deliver the system level changes needed and the vision for Leeds.

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.

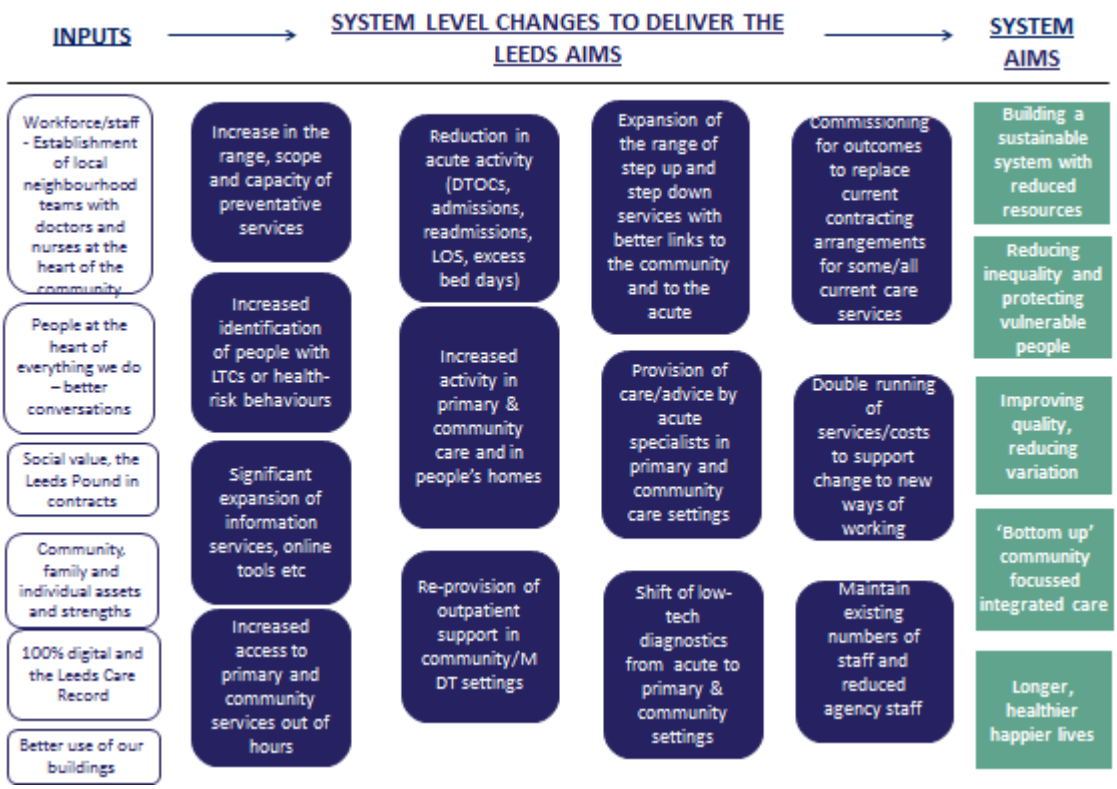
In a perfect system this work would take place before activities and processes were developed, however it is clear that there is a task to test / learn, include and align all the projects and programmes currently underway as part of commissioner- and provider-led work, as well as that future work planned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

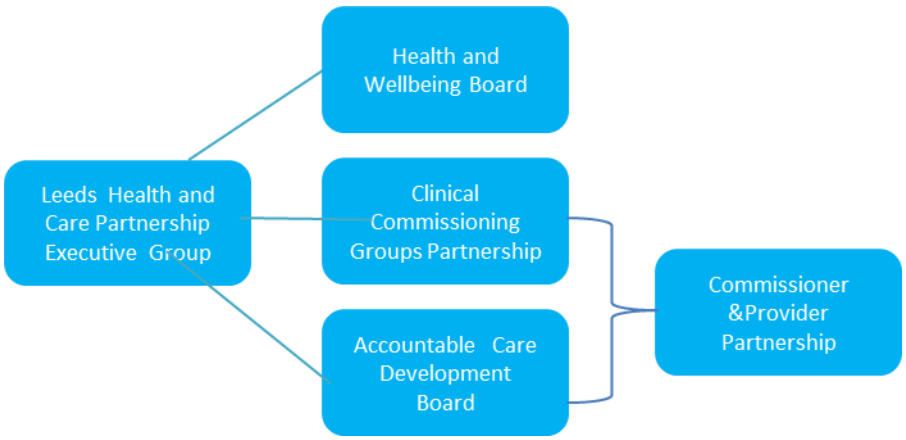
Delivering the **neighbourhood model** is articulated in the Leeds Plan refresh as a priority across the work programmes. More work is noted to be ongoing to translate these into actions and whole system changes.

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 and 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'.

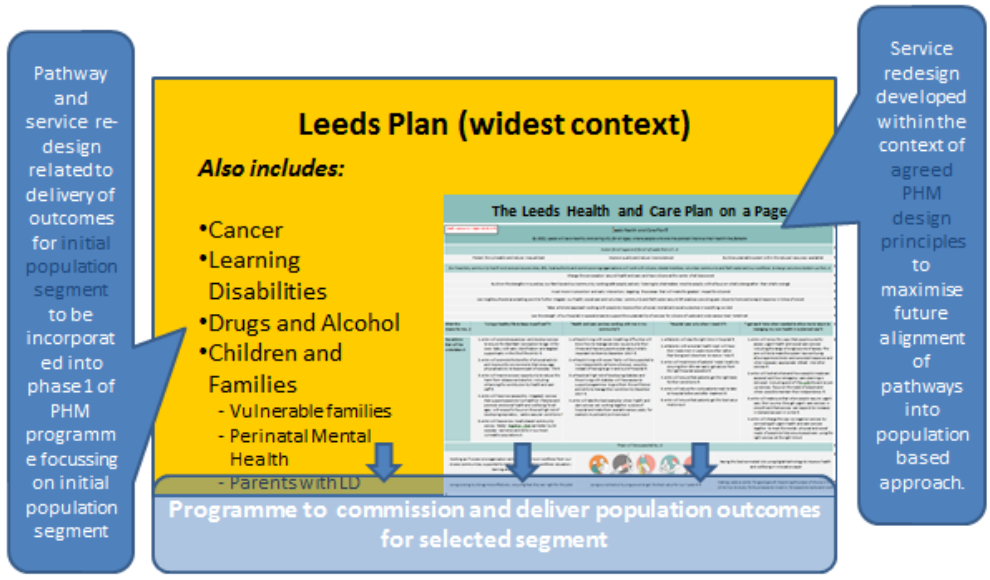
As was stated above, to succeed and achieve against these challenges, Leeds has to simultaneously balance the need to:

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

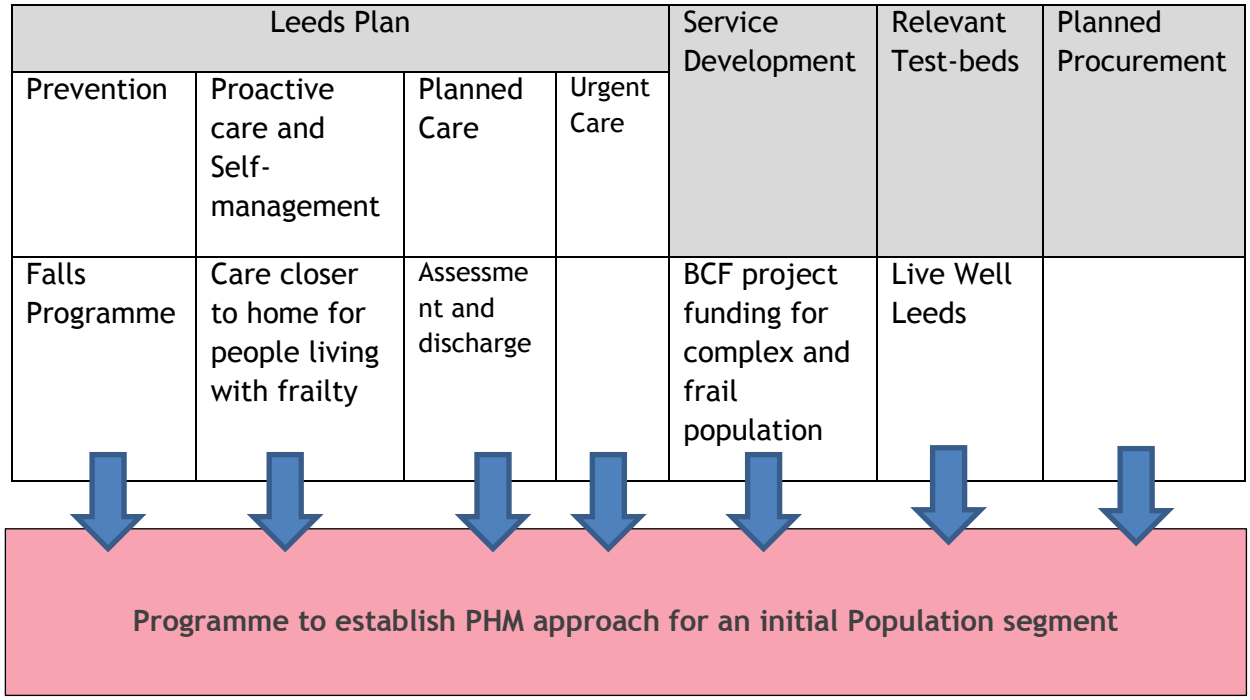


Within this approach, Leeds establishes a population based approach to commissioning and provision of outcomes for an initial, substantial, population segment while simultaneously continuing to deliver priority pathways as part of on-going Leeds Plan work. As part of this, pathway, service redesign and 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.

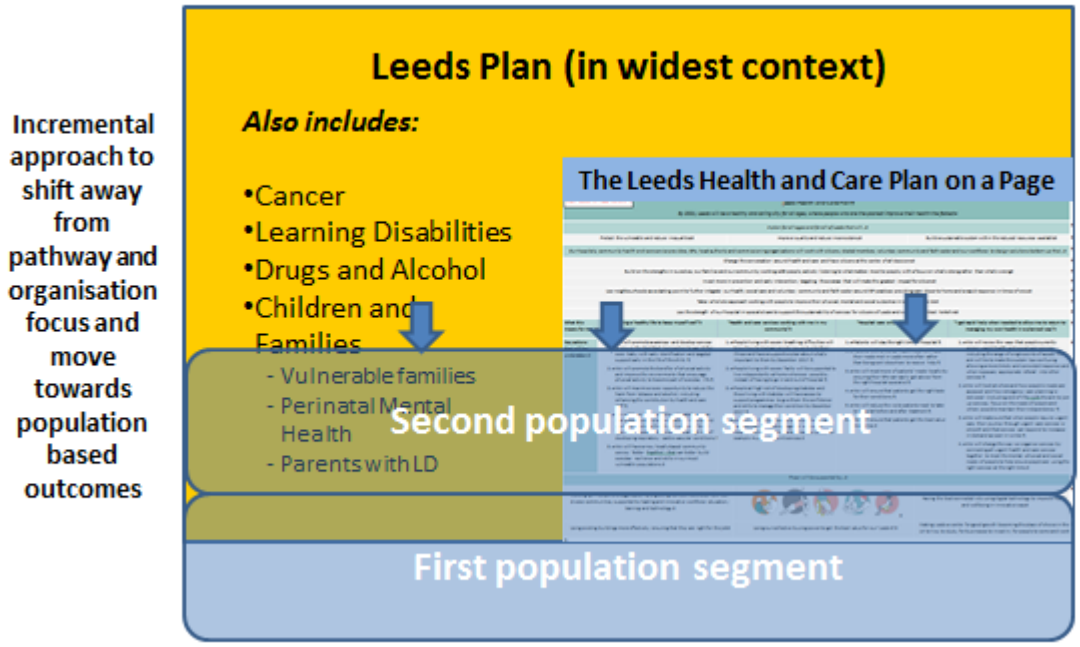
Purely by way of example, if Leeds chose the >65 population as its initial population segment for PHM, the following areas of service re-design, models of care and Leeds Plan deliverables would be subsumed into the programme. This scenario is depicted as an example in Figure 15 below:

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:
    - 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.
    - 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 – Link between Strategic Outcomes and Interventions (such as the neighbourhood teams/local health and care teams)

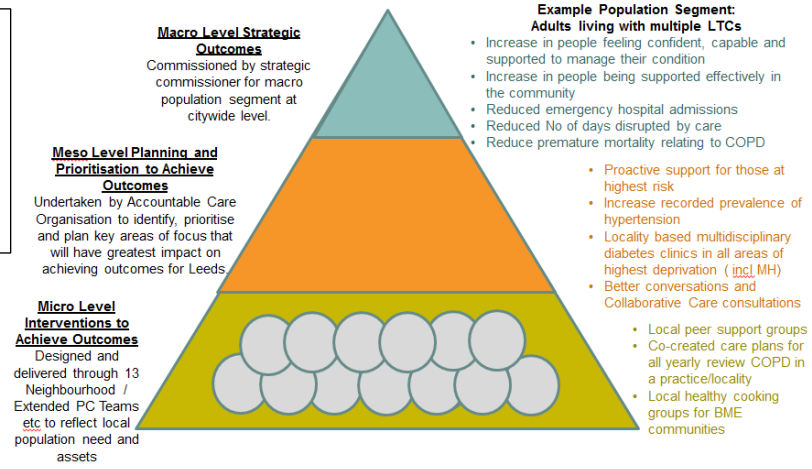


Figure 17 describes how this approach can be delivered, the table below sets out a high-level summary of the key functions, both as they sit currently and as they will be in the future.

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 bene 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. *See references for more information* 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. *See references below for more information* 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 Leeds Health and Wellbeing Board and it belongs to everyone in the city. *See references below for more information* 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. *See references below for more information* 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. *See references below for more information* 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. *See references below for more information* *https://www.england.nhs.uk/ourwork/new-care-models/*

NHS England (NHSE)	NHS England commissions specialised services, primary care, some public health services, offender healthcare and some services for the armed forces. It has four regional teams but is one single organisation operating to a common model with one board. *See references below for more information* 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. *See references below for more information* 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. *See references below for more information* 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. *See references below for more information* 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.
West Yorkshire Association of Acute Trusts (WYAAT)	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. *See references below for more information* 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. *See references below for more information* http://www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/

APPENDIX A

BLUE PRINT FOR POPULATION HEALTH MANAGEMENT ROADMAP

		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	SI														
	Identify and apply key learning and approaches adopted by other health and care communities.	SI														
	System alignment and Blueprint key messages discussion at PEG	BDO														
	PEG sign-off Blueprint	PEG														
	Organisational sign off of the Blueprint	Individual organisations														
Establish PHM delivery programme	Develop detailed programme plan (ensure ISAP timescales fully incorporated).	SI														
	Develop detailed Communications and Engagement Plan (including compelling public facing narrative)	SI & SC														
	Develop and agree programme structure Inc. PMO, Risk management, Governance, internal and external reporting arrangements	SI & HPT														
	Confirm leads and organisational resourcing (people) to deliver programme.	PHM														
	Deliver and position PHM Programme plan, structure and expectations within key fora (Inc. CCG SMT, PHM, Accountable Care Development Board, ICE).	PHM														
Workstream 1 Rapid Progress with PHM (Accelerator Segment)	Scope and confirm level of ambition for segmentation	SI/PHM														
	Undertake wider engagement to test and agree macro framework, prioritisation methodology and identify accelerator segment (including clinical input)	Segmentation workstream														
	Confirm governance to sign-off approach and recommended accelerator segment	PEG														
	Data analysis to support prioritisation of a population segment:	Public Health														
	Segment analysis - identifying how the population falls into each segment	PHM														
	Selection of first population segment (the Accelerator Segment)	PHM and extended workshop														
	Recommendation re initial accelerator segment to PEG	PEG														
	Undertake initial skills development in commissioning for outcomes for existing commissioning teams	SC														
	Set up Accelerator Segment Group	PHM														
	Develop plan for staged approach towards **all** population segments reflecting regulatory environment and lessons learned from other areas.	PHM														
	Develop methodology to agree financial envelopes for segments and produce first cut of budget for initial accelerator segment	PHM														
	Undertake modelling of financial envelopes for all segments.	PHM														
	Signal likely phasing of the future segment to be commissioned	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														TBC (Mar-19)
	Shadow form completes and moves into real outcome payment	SC & Providers														TBC (Apr-19)
	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