Five year strategy for Leeds
A view from the Leeds Unit of Planning – June submission.

Background - Leeds

Leeds has an ambition to be internationally renowned for its excellent health and social care economy and a vision to be the best city in the UK for health and wellbeing. The city faces many significant health and social care challenges commensurate with its size, diversity, urban density and history.

The Leeds Joint Strategic Needs Assessment (JSNA) identifies some of the significant issues for the city that impact on health including: deprivation, mental health, smoking, alcohol, obesity, cancer, cardio-vascular disease, dementia, children and young people's health, financial inclusion, older people's health and housing.

We have set two key challenges in terms of sustainability, to:

- Bring the overall cost of health and social care in Leeds within affordability limits - transformation is required to reduce current costs.
- Change the shape of health provision so that care is provided in the most appropriate setting.

To facilitate work to address these challenges we have developed the concept of the Leeds pound (£). This describes how we make the best use of our collective resource across the health and social care system, including public health taking shared responsibility for the financial challenge and achieving a financially sustainable system regardless of the source of the financial pressure. The plan for the Leeds £ is to create a sustainable high quality health and social care system fit for the next generation. This will be achieved by having a clear vision for how the health and social care system needs to operate and how it will be experienced by patients in the future. It will be underpinned by a comprehensive and integrated five year commissioning and services plan which has this strategy at its core.

It is estimated that all provider organisations in Leeds spend around £2.5bn a year on services. The NHS and LCC have funding challenges ahead with projected demand outstripping income. Through our economic modelling approach we have refined our calculations of the whole health system financial challenge and this is showing the estimated shortfall in our system as approximately £64.1 million in 15/16 which we expect to rise to £619 million over 5 years. The refined understanding is as a result of increasingly comprehensive modelling which now

includes both LCC and specialised commissioning latest figures. The combined CCG commissioning gap remains unchanged at £88.3 million. As the total local health economy budget is £1.7bn per annum then this deficit equates to approximately 7.3% of the overall budget.

With its size, ambition and health and wellbeing assets, Leeds has the ability to lead the way for healthcare delivery. Whilst doing so, the city faces a number of health challenges commensurate with its size, diversity, urban density and history. The concept of the Leeds £ helps to explain how making best use of our collective resource is the approach that is needed to address these challenges.

On the positive side Leeds has a unique collection of assets which it can draw on to face the challenges and achieve its ambition. These include three Universities, the largest teaching hospital in Europe, a thriving and engaged third sector, the geographical colocation of national bodies such as NHSE, The Information Centre, The Leadership Academy and excellent system leadership across health and social care.

Leeds Health and Wellbeing Board vision

The Leeds Health and Wellbeing Board (HWB) provides a forum for that leadership and has established an overall vision that: "*Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest*." Five outcomes have been set to demonstrate this vision:

- People will live longer and have healthier lives.
- People will live full, active and independent lives.
- People's quality of life will be improved by access to quality services.
- People will be involved in decisions made about them.
- People will live in healthy and sustainable communities.

Through the Joint Health and Wellbeing strategy we have also committed to ensuring that everyone will have the best start in life and grow up well in Leeds. This signals our recognition of how, what occurs in the first few years of life (from conception to age two - 1001 days) has a tremendous impact throughout the life course, from the full range of childhood outcomes, through to adult mental and physical health trajectories. Our partners in Leeds comprise of; health care providers, public health, social care, other Leeds City Council (LCC) services such as housing, the third sector and the public, patients and carers. Development of the strategy will be ongoing and can only be done in partnership with all these groups. Specific events have been held to ensure that the following groups have shaped the strategy. These are

shown as Appendix 1 - Timetable of engagement around Leeds Unit of Planning Strategy development. Engagement with these groups at strategic and programme level will be ongoing as we further develop the strategy and associated delivery plans including workforce, informatics, market development and estates with each group being involved as appropriate.

Commissioners working together

The three CCGs in Leeds are working together as one planning unit along with NHS England, they are:

- NHS Leeds North CCG.
- NHS Leeds South and East CCG.
- NHS Leeds West CCG.

Together we have agreed our vision and a way of working and built a shared commitment to this with Leeds County Council and the major service providers in the city. In addition to the responsibility each CCG has for delivering services in its geographical area we have nominated leads for commissioning areas to minimise duplication, increase decision making efficiency and avoid planning confusion. We are also working alongside NHS England to ensure that commissioning decisions support patient care, particularly for areas of specialist commissioning and primary care. Local work streams, such as locality and primary care development, are brought together through the meeting of lead officers in our Integrated Commissioning Executive (ICE).

As three CCGs in Leeds, we are working together to ensure that we contribute to the health aspect of this, as well as wider determinants where we can and providing system leadership. Thus we have adopted the vision of the Joint Health and Wellbeing Strategy which we shaped as agreed as members of the Health and Wellbeing Board:

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

All three CCGs support the Transformation Board which brings together all the key players across the city from health, social care, finance and public health, commissioning and provision. This board has six transformational programmes:

- Effective admission and discharge.
- Elective care.
- Urgent care.

- Optimisation of LTCs.
- Growing up in Leeds (Children's) programme.
- Non Clinical Support Systems.

We have also built ownership of several underpinning system changes that need to take place to enable transformational change to happen:

- Exploring contractual mechanisms and pay systems, aligning incentives and considering how money can follow risk.
- Using open book accounting.
- Using technology enablers to improve patient care and efficiency.
- Driving efficiencies in health and social care estates utilisation and in non-pay costs.
- Maximising our workforce including transferring the workforce to meet the needs of patients. In this way we can maximise the experience of our staff and minimise cost as well as ensuring we have a future proof Leeds health and social care workforce.
- Freeing up efficiencies from IT, back office system and processes to remove duplication to minimise the financial impact on frontline clinical services.

How we are developing the services to meet national requirements

There are several key indicators that have helped us design programmes and work plans that we will use as a delivery route for our vision. These include the six characteristics, as well as those for general practice, the seven ambitions and the five outcomes described to meet our vision. Our strategic plan includes specific actions to support development of our general practice services to support and reflect the six key characteristics of high-quality care set out in the general practice *A Call to Action.* In order to deliver this complex agenda we have taken an integrated programme approach across the city, linking in the all key provider, LCC and public health. This is brought together under the Transformation Board and its programmes. The governance arrangements for this are shown in appendix 2 - Transformation Board governance structure.

The Leeds way of doing things

We have set two key challenges in terms of sustainability, to:

- Bring the overall cost of health and social care in Leeds within affordability limits - transformation is required to reduce current costs.
- Change the shape of health provision so that care is provided in the most appropriate setting.

We have identified three key issues which we wish to address through the delivery of these programmes:

- Improving health.
- Reducing health inequalities.
- Parity of esteem.

To define how different changes are planned we have described our approach to change in a clear model (attached as appendix 3 - The Leeds approach to change management). This describes how we ensure that different kinds of change in the system get the right kind of approach to optimise the likelihood of success. with three different ways of progressing different types of change:

- For normal everyday improvements, such as increasing efficiency, we will use improvement models such as SPC and our usual supportive performance and contract management arrangements .
- For quality improvement we are using the Leeds Institute for Quality Healthcare (LIQH – with our academic partner) work to develop the skills of our leaders and clinicians to make significant quality improvements and reduce variation in all aspects of our health care system.
- For large changes to the system we are using a transformational Outcomes Based Accountability (OBA) approach supported by economic modelling and business capability modelling, underpinned by rigorous portfolio management and working through transformational programmes which are described below.

There are already many workstreams delivering improvements and new initiatives, such as the Better Care Fund (BCF), are showing efficiencies from joined up working. Ideas such as linking health and wealth and defining the best use of the Leeds £ contribute to the work to improve the long term health of the population of Leeds by addressing inequalities and the fundamental causes of ill health.

Outcome based accountability

We have agreed through the Transformation Board to use an Outcome Based Accountability (OBA) approach in designing the programmes and the measures for success within it. This reflects the approach taken by LCC and the HWBB. Our OBA approach allows us to be clear about what we are achieving strategically and ensure that the transformational programmes deliver results for the public and patients and make a

difference to service users. This is particularly important in recognising and addressing health inequalities and identifying the outcomes that will improve those with the poorest health the fastest.

Definition of outcomes, indicators and measures

By adopting an OBA approach across the Transformation Board's programmes we have agreement of terms to ensure a common language. The key terms that we use precisely through this approach are outcome, indicator and measure.

Transformation programmes will report on progress towards the change in the system needed to improve care and quality. The five outcomes defined for our vision have been mapped to the six characteristics and will be used to define success in these areas. We have added an additional outcome of 'financial stability of the Leeds Health Economy'. The mapping of this is shown as Appendix 4 - How the Leeds indicators link to the five outcomes of the Joint Health and Wellbeing Strategy. The work in each the transformational programmes will deliver the transformational change we need to meet the six characteristics and our vision and we have used the seven ambitions as a measure for achievement. The mapping of this is shown as Appendix 5 - How the Leeds indicators link to the seven ambitions. Behind the seven ambitions the indicators that the transformational programmes have developed with stakeholders have been mapped so that we can monitor progress towards achieving the outcomes for the programmes and for the Leeds vision. All current and future transformation programmes are expected to map their activities to these outcomes and to make a contribution accordingly.

In mapping the indicators into the economic modelling tool we have indicated our level of confidence of delivery. All initiatives have a current "status" providing three levels of confidence – High for known savings, Medium for estimated savings and Low for unknown detail where the activities to deliver the savings identified through the opportunity assessment have yet to be programmed.

Transformational programmes

There are six transformational programmes that will secure the change needed across the city to ensure that all patient care is of exceptional quality as well as being delivered closer to home with better value for money.

Programme Structure

- **Elective care** - Programme focusing on transforming elective care across health and social care. Transformation will be across all elective care specialties, but immediate focus would be on areas of high spend (absolute and compared with other economies) and on pathways where there are presently poor or unproven clinical outcomes. Also MSK and cancer follow ups could be initial areas of focus. Transformation of elective care may focus on; joint decision making with patients, provision of services in a community setting and reducing dependence on hospital outpatients.
- **Prevention and optimisation of LTC** - Prevention and optimisation of management of patients with long term conditions, frail elderly, EOL, dementia and multiple comorbidities. Includes optimisation of identification and application of evidence based frameworks for management of conditions.
- **Urgent care** - Programme focusing on urgent care arrangements. Links with optimising of LTC programme, but also targets urgent care for those not in those groups. Will include use of Accident and Emergency, ambulances and Out Of Hours provision of primary care.
- **Effective admission and discharge** - Integrated management of patients to reduce dependence on secondary care beds. Programme will focus on; preventing admission from A&E, early supported discharge, appropriate discharge and prevention of re-admissions.
- **Growing up in Leeds (Children's) programme** – This programme is being developed from the on-going children's programme of work. We have identified specific groups of children and young people where we will focus our commissioning efforts to improve outcomes over the next few years. These are children in the Care system and Care Leavers, children with complex need and disability (including SEN needs) and children and young people with emotional and mental health needs.
- **Non Clinical Support Systems** - Programme considering the provision of services not directly related to care, plus non-pay spend that supports care. The focus will be on generating savings from estates, and from procurement of goods and services across the economy. It would also focus on provision of support services such as finance, IT including better use of NHS numbers, and quality including safeguarding and workforce issues including satisfaction, qualification and training (with NHS England and the LETB and vocational training within provider settings) across the economy.

In addition to these programmes we will also be considering mental health, learning disabilities and wider primary care development as areas of opportunity to enable the new health system to be delivered in its entirety. Elements of these models of care involve wider conversations and we will continue to engage with NHS England commissioners and West Yorkshire programmes to ensure strategies are integrated and consistent.

Principles

We have devised a set of principles about how we achieve integration across all health and social care services in partnership with our providers. These reflect the key concepts of commissioning for the needs of a population rather than for provider structures, and aligning finance and risk to enable the provider system to respond to the needs of that population:

- Integration can be used as a tool to address the needs of populations – both as a model of care and as a model of commissioning.
- Operational delivery/sign off of the Target Operating Model for integration during 2014/15 and the Better Care Fund must continue at pace and should not be affected.
- Money should follow risk in the system and capitated budgets could facilitate this.
- Explore accountable provider structures for particular populations, cohorts or pathways as determined by need and potential for quality improvements.
- The system should remain flexible to adapt to emerging needs.
- We will work in collaboration with commissioners and providers over the most appropriate geographical footprint to optimise services for our population.

We also believe that:

- The involvement of patients and the public at large is a key part of developing sustainable plans for the city.
- Primary Care will need to become even more central to patient care and deliver a wider range of services.
- We must use the latest evidence to obtain best outcomes for patients.
- We must use the latest technology to enable patients to be seen by the right professional at the right time in the right place.
- We should deliver care as close to patients' home as is safe and efficient.
- We must enable patients to take more control of their health and care.
- We should convert urgent care into planned care where possible – plan discharge prior to event.
- We must deliver high quality services with equal access to all communities.
- We must ensure more productive use of NHS buildings and resources.
- We should turn data into intelligence to inform commissioning decisions.
- We must maintain financial sustainability and commission based on value for money.

Measures

Our trajectories have been based on statistical modelling and commissioner aspiration and have been triangulated with the five outcomes. Further modelling will continue at work programme level to ensure that we are able to manage delivery.

We will continue to develop meaningful measures for the systems and the component parts to ensure that we are able to understand the impact of our actions. This will continue to include Outcomes Based Accountability as well as analytical and modelling tools. All of our transformational programmes have set themselves measures to determine their success. In each programme measures include: access, quality, innovation and value for money. It will only be by delivering all these areas of work that we will be able to transform the model of care.

The indicators will be managed by effective governance and rigorous portfolio management techniques through the Transformation Board and the key transformation programme leads regularly come together to view overall achievement and give account to the Transformation Board. Sharing progress towards outcome indicators for all the transformational programmes throughout the system will demonstrate and quantify what we are achieving in terms of delivery through our combined efforts.

Financial and future state modelling

The Leeds Economic Modelling tool has been developed with the Commissioning Support Unit and Ernst and Young and has used data collected by the CCGs and providers. Using the tool we have been able to get fine detail in terms of modelling and trend analysis. Using an OBA approach we have focused on the "as is" state but took a decision that data older than 2012 was not relevant to our scoping of what we expect to see in five years time and particularly to how we plan "to turn the curve" and make changes to the system that improves patient experience and improves effectiveness and efficiency to reduce costs in the longer term. Therefore we used "as-is" data only as the baseline (unless there was a very specific reason why historic data was needed) and then modelled the change expectations "to-be" through the plans of the transformational programmes, local action and other outcomes based predications.

From the key considerations we have defined five key factors underpinning the modelling. These have been understood and agreed by all organisations within the Leeds health economy for the next five years:

- **Factor 1:** The base financial position for all organisations.
- **Factor 2:** Future efficiency and allocation requirements for all providers and commissioners.

- **Factor 3:** Impact of future activity growth within the economy.
- **Factor 4:** Impact of future activity growth outside of the economy which local CCGs will pay for.
- **Factor 5:** Financial margins on future activity growth.

Through our economic modelling approach we have refined our calculations of the whole system financial challenge and this is showing the estimated shortfall in our system as approximately £64.1 million in 15/16 which we expect to rise to £619 million over 5 years. The refined understanding is as a result of increasingly comprehensive modelling which now includes both LCC and specialised commissioning latest figures. The combined CCG commissioning gap remains unchanged at £88.3 million. As the total local health economy budget is £1.7bn per annum then this deficit equates to approximately 7.3% of the overall budget.

Coupling the approach described and the assumptions described the overall financial challenge facing the Leeds Health Economy (LHE) is £619m in five years. The breakdown of how that is split across organisations is shown below:

£'m	**TOTAL**
LTHT	(306.0)
LYPFT	(36.4)
LCH	(31.6)
YAS	(6.1)
Leeds North CCG	(23.4)
Leeds South and East CCG	(35.8)
Leeds West CCG	(29.1)
Leeds City Council	(75.9)
NHS England	(74.7)
TOTAL Challenge	**(619.0)**

As a result of one-to-one meetings with NHS providers and from discussions with CCGs, the financial challenge is as expected for those organisations. However a large proportion of the overall financial challenge is a result of the forecast pressures facing Leeds City Council (LCC) and NHS England, both of which are still to be fully verified. Over the five years the profile is £64.1m (Yr 1), £120.2m (Yr2), £161.7m (Yr3),

£129.7m (Yr4) and £143.3m(Year 5). As the total LHE budget is 1.7bn per annum then this deficit equates to approximately 7.3% of the overall budget i.e. £ 619m/£ 8.5bn.

Provider Challenge

The total of efficiency requirements for the providers in the LHE over the next five years is £380.1M. The majority of this is attributed to LTHT who are also forecasting a much larger efficiency requirement over the next five years (5% - 8%) due to the underlying deficit position the trust is in. If all of LTHT's £306.0m of efficiencies are found recurrently over the period then the trust will reach its 1% surplus requirements. The breakdown of LTHT's efficiency requirements over the next five years is:

£K	Year 1	Year 2	Year 3	Year 4	Year 5
Efficiency Requirement	(54,000)	(72,000)	(80,000)	(50,000)	(50,000)

From discussions there is confidence that some mitigation of the gap could be achieved but would involve these additional savings year on year. Monitor's target of 4.2% - 4.7% is already difficult and many organisations fail to meet this lower level.

Better Care Fund – Calculating the Return of Investment (ROI)

The total value of the Leeds Better Care Fund (BCF) is in excess of £55million. It is a fund of a size that can make a real different to patients and the people of Leeds. The concept of the Leeds £ (a common currency that runs through all of health and social care services in the city) is already well established, and the establishment of the BCF signals that this is now being brought into reality.

The city has set itself a target of a reducing the number of emergency admissions to hospital by 15% over the next five years, against a backdrop of increasing demographic growth and therefore demand. If the city were to continue on its current trajectory and factoring continued increases in demand, in five years' time the city would be spending over £163 million on emergency admissions

It is on this figure that a reduction of 15% has been modelled. If successful the city will save £24millon on where it should be, which is equivalent to an £11.4 million real terms reduction in spending. Investments from the BCF will support the delivery of these savings. The breakdown is Leeds West - £10.7m, Leeds North - £12.4m, Leeds SE - £12.3m and is a **recurrent** investment in the BCF.

The Commissioner Challenge - 'Formula to Success'

Where possible we have aligned the Provider and Commissioner Plans to ensure we are relating the same scenarios. We have used the Right Care (Commissioning for Value) split to provide a relative split across the CCGs. Transformation Programme planning is based on 'Outcomes and Measures', Initiatives to give a per programme total. The CCG CFV analysis has shown a breakdown of the deficit is:

Clinical Commissioning Group (CCG)	**Economic Modelling (£K over 1 Year)**	**Percentage breakdown Right Care analysis (%)**	**Max potential saving (CfV)**
			Top Quartile in peer group (1 Year)
Leeds North	2,792	15.8%	6,207
Leeds S&E	6,100	34.5%	13,560
Leeds West	8,768	49.6%	19,493
1 Year Total	**17,660**	**100%**	**39,260**
5 Year Total	**88,300**		

It should be noted that many of the local CCG initiatives are enhancing and supporting transformation. All initiatives have a current "status" providing three levels of confidence – High for known savings, Medium for estimated savings and Low for unknown detail (at this stage). This is then subtracted from Total Deficit (£-88M) to give the forecast gap to be bridged/deficit that cannot be met at this stage of planning. The detailed breakdown is shown below:

		5 Year Breakdown					
Main Assumptions	**Status**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**Total (£K)**
Savings to Execute (Inc 1% Surplus)		**6,500**	**12,000**	**18,000**	**24,000**	**27,800**	**88,300**
	High	721.8	1,922.2	1,997.0	2,170.4	2,469.4	**9,280.8**

Transformation Programmes	Medium	1,158.6	2,295.7	3,117.7	3,918.8	4,699.2	**15,190.1**
	Low	477.6	944.8	1,340.3	1,725.9	2,101.4	**6,590.0**
	Total	**2,358.0**	**5,162.7**	**6,455.0**	**7,815.1**	**9,270.1**	**31,060.9**
Additional Factors							
Local plans still to be verified	Medium	176.8	387.2	484.1	586.1	695.3	2,330
Better Care Fund (BCF) programmes to be added	High	1,798.4	2,252.5	2,312.0	2,511.6	2,485.6	11,360
Total Initiatives		**4,333.2**	**7,802.4**	**9,251.2**	**10,912.8**	**12,450.9**	**44,750**
Forecast Gap to be Bridged		2,166.8	4,197.6	8,748.8	13,087.2	15,349.1	**43,550**

This £43.6m represents the forecast gap remaining to be bridged for CCG commissioned services only and does not include the forecast gap of £74.7m for NHS England commissioned services for which the plan is still under development, or the residual provider financial challenge of at least £60m. Of the forecast shortfall of £619m the system has in excess of a further £178m savings to deliver which are currently unprogrammed.

Engagement and sign up

We have worked across the city to ensure that we have reflected what people have told us they want their healthcare system to look like. A full list of engagement with partners, providers and the public is attached as appendix 1 and the strategy has been discussed and signed off by

key bodies including the three CCGs and the HWB. We know that this strategy reflects a point in the process and have established systems that allow conversations to continue across the city that ensure a joined up and coherent way of working together not only to continue to develop the strategy but ensure its delivery. This includes conversations about:

- Links to clinical programs on CVD, fractured neck of femur and respiratory as well as pathway design changes and improvements that are happening in organisations and between them.
- Increasing quality across the system through system leadership workshops that work with the medical and nursing senate and the Leeds Institute of Quality Health care.
- The transformational programmes at the Transformation Board and the HWB.

Our new healthcare system

Developing the strategy to this point is only the start of the journey. There is work to be delivered over years one and two of the strategy timeline to make improvements to the system that are transactional and will deliver some of the changes in the system we need. Without these first steps we will not be able to prepare the system, and the users of the system, for the changes we need to make. The real transformational impact will be seen from year three onwards. Here we need primary care to be expanding its role to allow and support more community care and care closer to home.

We have set two key challenges in terms of sustainability to:

- Bring the overall cost of health and social care in Leeds within affordability limits - transformation is required to reduce current costs.
- Change the shape of health provision so that care is provided in the most appropriate setting.

We expect that the improvement in quality and generic improvement activities will contribute to the financial gap we know we need to close. But the biggest impact on the healthcare system and on the experience of patients (in a positive way) will be the reorganisation of key parts of the system to generate a new way of working.

Six characteristics

Each of the six characteristics are described below with how we are planning to meet them through the implementation of our transformational programmes.

Citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care

Vision

To build a local health and social care system that supports individuals to be in control of their own care, enables local communities to influence and control commissioning decisions, and ensures patient experience measures are used as a key driver for change.

Present state

The involvement of patients has previously been variable in effectiveness and quality and often a bolt on or single issue activity with limited impact and benefit to patients and the NHS. Appropriate and representative members of our population have not always been involved and we have tended to ask for people's views but have not been clear or transparent about how what we learned informed the decision we made.

The NHS Call to Action has provided us with a platform to further strengthen our engagement with the public more widely. Leaders of the city have explained the unique pressures facing the NHS, and built understanding and broader engagement into future strategy and plans. The concept of investing in social care and integrated care to reduce the need for urgent and acute healthcare is one that is being promoted in the city and actively discussed at patient and public forums across the city. A city wide report has been prepared and analysed and each CCG has a Call to Action engagement programme. From the Call to Action work we have identified key recommendations:

- Staffing - increasing and providing staff with training and qualifications to be able to improve the quality of care they provide.
- Access to services – better access to services, 24/7 access to services, services closer to home.
- Promotion - focus on communications and promotion of activities and advice to improve people's health and wellbeing, including communication with children and parents through working with schools.
- Prevention – focus on providing more screening services and education programmes.

Future state

Patients are already involved in designing services and shaping change. In addition to patient advisory and liaison groups, patients are also represented in person on our boards and steering groups. This means that commissioner plans involve patients and are challenged and scrutinised internally by patients before implementation. We believe that this process of engagement makes our re-designed services stronger and more focussed on patients and their needs. For Call to Action individual CCGs responses are linked through the transformational programmes and the success of this will be monitored through the Transformation Board. Our investment in Asset Based Engagement models, Working Voices and other models of engagement, including the citizens' panel of the LCC, will develop our engagement into a meaningful ongoing discussion with our community and include views of those who have traditionally been seen as hard to reach. The roll out of Friends and Family test and Personalised Healthcare Budgets will support this.

Issues and gaps

Including patients and carers in the design and change of services has already started in each of the programmes. PPI and involvement of the views of patients and carers will be a key way of working for all the transformational programmes and this will be part of the governance structure and challenge from not only the individual CCGs but also the Transformation Board.

Outcomes

- People will be involved in decisions made about them.
- People will live in healthy and sustainable communities.

Measurement

- Increasing the number of people having a positive experience of hospital care.
- Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community.

Activities

We will do this by:

- Using asset based engagement.
- Seeking and using customer insight.
- Working with, and through, elected members to ensure that health care system changes reflect and meet local need.
- Working through neighbourhood networks.

- Ensuring all individuals and communities have equitable access to ill health prevention activities.
- Developing our workforce to have the skills, knowledge and culture to support individuals to self-care.
- Effective use of patient decision support tools.
- Adopting the principals from the House of Care model.
- Maximising use of new technologies.

Sustainability
Increase in the emphasis on self-care will be key especially in long term condition management. We need to ensure that patients are empowered to do this and not expected to take a more active role in their care with no additional training or support. By using the Year of Care programme we will make consultations truly collaborative through care planning.

Wider primary care, provided at scale

Vision
Primary care teams will be at the heart of the patient pathway.

Present state
Member practices of each CCG have been working to develop their local strategies and frameworks and look at how they not only improve the quality but also the range and configuration of care and supporting services they offer alongside their role as clinical commissioners. For some time they have been using a risk stratification tool to help clinicians identify those patients, particularly Vulnerable Older People (VOPs) who have higher levels of need in order to respond to this priority group. Recently we have developed 13 integrated teams wrapped around practices across the city, working with service users, GPs and the third sector to help deliver better integration and seamless care. Each CCG is working to develop more representative clinical leadership and involvement process to ensure an equal voice and contribution from all primary care professionals and localities across the CCG. Member practices own the strategic and operational direction of the organisation.

Future state

We want to improve the quality and range of services offered in general practice to ensure that all patients have timely access to high quality, safe services. Primary care will not only coordinate much of the care and be a key point of delivery, but it will ensure that others have the skills they need to support the patient through training and offering advice and guidance. There will also be access specialist advice and guidance, for example from secondary care consultants, and this will be though making better use of technology and tele medicine. This is supported by the work that is happening on the West Yorkshire footprint creating an environment which enables general practice to play a much stronger role as part of an integrated system of out of hospital care. The detail of this work is attached as appendix 4.

Issues and gaps

To improve our primary care structure we need to support the development of general practice services. They will require investment and innovation to improve access and quality of care for patients particularly as we move more services from a hospital setting to community environments. Thus we need to align incentives to allow this change. The work in Year of Care is examining how this can happen within the contracting framework. Work to address how we can support those who have mental health issues and learning disability will also require support from primary care.

Outcomes

- People will live full active and independent lives.
- People's quality of life will be improved by access to quality services.
- People will live in healthy and sustainable communities.
- Financial stability of the Leeds Health Economy.

Measurement

- Improving the health related quality of life of people with one or more long-term conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community.

Activities

We will do this by:

- Effectively managing clinical risk at an individual and population level.
- Recognising continuity of care as a key enabler.
- Tackling unwarranted variation through collaboration and shared learning.
- Embedding integrated working between General Practice providers.
- General practice leading integrated out of hospital care to meet the needs of the local population.
- Working with local communities and Primary Care providers to improve access by developing capacity to meet population need.

Sustainability
To make the whole system sustainable we need to have a primary care resource that is able to respond quickly and effectively to patient need and able to support making mental health and physical health services more integrated and the aspiration of mental health services to transform to be recovery and outcome focussed. This will require services to move into the community alongside reductions in bed bases or other facilities that are delivered through productivity and pathway improvements. Aligning incentives will be important to make this happen.

A modern model of integrated care

Vision
We will provide patient centred care for people by addressing the challenges of having multiple providers of care so resulting in a greater quality of care and more effective use of resources.

There are two key transformational programmes that support the delivery of integrated care from a patient perspective. These are effective admission and discharge programme and the Long Term Conditions, Dementia, Frail Older People and End of Life Care programme.

Present state
There are already a range of initiatives across the city to improve prevention and care for the cohort of the population who are most at risk of poor health and reduced life expectancy including those with LTCs. However, the implementation of initiatives is variable across the city. Over 65s account for more than half of all non-elective hospital stays with a duration of more than 2 days.

The locally agreed approach has been to use BCF as an opportunity to further strengthen integrated working and to focus on preventive services through reducing demand on the acute sector. Along with our work as one of the 14 Pioneer sites we have started to demonstrate improvements to services and release of funds. BCF will be used to derive maximum benefit to meet the financial challenge facing the whole health and social care system over the next five years. These improvements are reflected in our economic modelling but there is more to do particularly around testing approaches to funding and delivery of integrated care.

Future state
We are using the Year of Care tariff work to look at different pay systems to support work on integration and increased community provision. Organisational boundaries in the future will need to be more permeable with staff working to support and care for people as part of interdisciplinary endeavour. We are also committed to ensuring that everyone will have the best start in life. This signals our recognition that what occurs in the first few years of life (from conception to age two) has a tremendous impact throughout the life course, from the full range of childhood outcomes, through to adult mental and physical health trajectories.

Issues and gaps
We know that the projects we have put in place already are focussing on the right things. However we also know that there is variation in implementation across the city. We will build on present work to develop it further and ensure a consistent and joined up approach for Leeds.

Outcomes

- People will live longer and have healthier lives.
- People will live full active and independent lives.
- People’s quality of life will be improved by access to quality services.
- People will be involved in decisions made about them.
- Financial stability of the Leeds Health Economy.

Measurement

- Securing additional years of life for your local population with treatable conditions.
- Improving the health related quality of life of people with one or more long-term conditions.

- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people having a positive experience of hospital care.

Activities

We will do this by:

- Ensuring we understand individuals and populations who are at risk now and in the future and ensuring they are known to the health and social care system.
- Developing community based service models that are clinically integrated across social, primary, community and secondary care and incorporate the principles of the House of Care model.
- Building trust and understanding between culturally different care workers to ensure effective working with clear accountability.
- Maximising improvement in quality through the Leeds Institute for Quality Healthcare (LIQH) work across the whole care pathway.
- Optimise linkage to, and use of, community assets (including neighbourhood networks).
- Maximising the use of new technologies that identify risk, integrate care records and support self-care.
- Aligning incentives across multiple providers by developing common outcomes, indicators and performance measures.
- Exploring new contracting models that incentivise a modern model of integration and reflect accountability and risk.

Sustainability

We need to ensure that care follows the patients with organisational boundaries being more permeable and staff working to support and care for people as part of interdisciplinary endeavour. Increased use of electronic records to facilitate shared care between primary and secondary care clinicians, including electronic consultations and referrals will eliminate duplication and unnecessary repetition of tests as well as supporting those working in a community setting to provide care closer to home. Support to ensure that patients return home quickly after a hospital admission and that they avoid unnecessary admissions will be supported by contractual arrangements.

Access to the highest quality urgent and emergency care

Vision
Provide an Urgent Care and Emergency system that delivers the best achievable outcomes for individuals with an acute or perceived urgent care need.

Present state
Leeds has a "well performing" urgent care system (when measured against national parameters). However the system presently (in part) drives failure led behaviours (pushing people to ED), brought about by the system not functioning as a cohesive whole. Early engagement work suggests this lack of continuity is one of the things the public would like to change.

We also have disproportionately high usage of urgent care services in some areas of the city and more targeted work is required to improve service provision in these areas. An example of this is a focus on our more deprived wards specifically around the central and south areas of the city.

Future state
We will develop a new model of care that will have improved clinical outcomes and patient experience by shaping services around the needs of patient populations whilst being better value for money. This will include making 111 the default place for early signposting and information, ensuring that patients only 'Walk In' (initiate contact) once and establishing clear brands for 111, 999, GP, and hospital services.

Issues and gaps
The system in Leeds is presently very traditional in its service delivery. To overcome the challenges we need to be more creative and innovative in developing new solutions to address our current issues. The scope of change will have significant consequences for our provider organisations. Ensuring all stakeholders are fully invested in systemic change and understand the case for change poses a challenge. Patient needs, perceptions and behaviours need to be fully understood to ensure we build a system that is responsive to the way patients actually behave. We need to understand patient behaviours and build systems so that they complement (rather than contradict) these behaviours.

Outcomes
- People's quality of life will be improved by access to quality services.
- People will be involved in decisions made about them.

- Financial stability of the Leeds Health Economy.

Measurement
- Securing additional years of life for your local population with treatable conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Activities
We will do this by:
- Providing a planned response to urgent care needs which can be identified in advance and a responsive appropriate service for those which can't.
- Aligning services and resources to the needs of patient populations.
- Providing new service responses for the intoxicated.
- Enhancing services for people with mental health needs.
- Providing timely access to urgent primary care for children.

Delivery will be via a series of projects for specific population cohorts: frail and elderly, mental health, children and young people and alcohol.

Sustainability
A key part of the urgent care strategy will be building a system that is responsive to changes in demand. An agile system will be developed that is able to flex and change to reflect both short term (e.g. daily or seasonal) and long term (e.g. demographic, epidemiological) changes to demand, whilst continuing to deliver high quality outcomes. All system redesign and commissioning action will incorporate the surge and escalation contributions of the service. Whilst quality is our main driver for this work, national evidence suggests that the provision of high quality, responsive urgent care delivers financial savings as duplication is reduced, productivity increased, hospital admissions and length of stay are reduced and morbidity and mortality are reduced.

A step-change in the productivity of elective care

Vision

We will reduce differences in life expectancy and patient experience by working together to have the best planned care and diagnostic services.

Present state

Our present system doesn't always identify those individuals for whom earlier interventions would lead to their remaining healthy and independent for longer. We often still use traditional methods for advice and guidance; with face to face follow up appointments the only offer available to some groups of patients and carers. In previous years we have seen continued growth in elective and diagnostic procedures within secondary care settings with a limited offer in the community.

Future state

We want to have a system that ensures equitable access to services for elective and diagnostic procedures from a variety of providers. They will offer high quality outpatient, diagnostic, inpatient and day case provision easily accessible to the local population. Diagnostic tests will be available in convenient locations with short waiting times for routine appointments and timely electronic reporting to requesters. There will also be increased numbers of outpatient services for stable patients delivered by appropriately skilled clinicians in community settings. The elective redesign work programme is to cover all routine outpatient, diagnostic, elective inpatient and day case activity commissioned by Leeds CCGs for the Leeds population.

Issues and gaps

We recognise that all partners will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies within the whole system of care to ensure that the health and care system remains sustainable.

Outcomes

- People's quality of life will be improved by access to quality services.
- Financial stability of the Leeds Health Economy.
- People will be involved in decisions made about them.

Measurement

- Securing additional years of life for your local population with treatable conditions.

- Increasing the number of people having a positive experience of hospital care.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Activities

We will do this by:

- Using patient decision support to meet individual need.
- Harnessing micro commissioning to meet local need.
- Ensuring care flows for patients with pathways without boundaries.
- Making effective use of the third sector.
- Maximising improvement in quality through the LIQH work.
- Using the latest evidence to obtain best outcomes for patients.
- Using the latest technology to enable patients to be seen by the right professional at the right time in the right place.
- Ensuing delivery of care is as close to the patient's home as is safe and efficient.
- Delivering high quality services with equal access to all communities.

Sustainability

Our plan to ensure that changes are sustainable by achieving waiting times for outpatient, diagnostic and inpatients fall within the NHS Constitution requirements. This will be alongside reductions in bed bases or other facilities that are delivered through productivity and pathway improvements.

Timely elective care will reduce spend further downstream in the health system in the long term, however, in order to achieve this there will need to be a culture shift across the health system to acknowledge the priority which needs to be given to planned care in the future. We recognise that developing a broader range of clinically led, community based services will require the collective pooling of resources to effect the movement of funding from acute and long term care models to those new community based services.

Specialised services concentrated in centres of excellence

Vision

The Leeds CCGs and NHS England will join together to ensure that we are able to support our local providers to deliver services as centres of excellence.

Present state

West Yorkshire has created specialist planning workstreams (attached as appendices 6 -11[1]) and shared programmes of work to bring together commissioners where services are delivered on a wider footprint than the Unit of Planning. Areas of work are:

- Criminal Justice System – the impact on CCGs has been described including liaison and diversion, SARC development and custodial healthcare.
- General practice – work of the 10CCs considers how we jointly commission services as well as improve quality, develop infrastructure, redesign services and support investment and empower clinicians and the patients and public.
- Dental services – describes care in line with the Leeds vision including increased planned care, reduced inequity and improved patient and public information.
- Public health commissioning's vision of making affordable high value health services available to all to improve the health and wellbeing of our population and reduce health inequalities will be delivered through 6 West Yorkshire wide objectives that will be measured through our HWB.
- Armed forces workstream which has developed a strategy with particular overlaps for mental health and complex physical needs support.
- Cancer workstream which has a vision to provide world class cancer services that deliver improved outcomes and survival rates of the patients of West Yorkshire such that they meet, and where possible exceed, those of comparative global healthcare systems. The impact on LTHT as a specialist provider links into our LTC and elective care transformational programmes.
- Stroke workstream which has a vision to reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire health economy, minimising the long term effects and improving the quality of life for survivors. This will be achieved by providing consistently high quality care that is responsive to individual needs and through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke. This links to our LTC transformational programme and aligns with our health inequality agenda.

[1] Appendix 6 - NHS England direct commissioning - Health and Justice Issues; Appendix 7 - Strategic Framework for Action – General Practice in West Yorkshire; Appendix 8 - NHS England West Yorkshire plan on a page primary care, secondary care dental and pharmacy; Appendix 9 – direct commissioning plan on a page public health, Appendix 10 – Armed Forces Health Commissioning plan on a page; and Appendix 11 - West Yorkshire Chapter – containing information on Stroke, Cancer, Urgent and Emergency Care and Paediatrics Services.

- Urgent and emergency care workstream which has an aspiration that our population will be able to access enhanced primary and community care services and will learn through their consistent experience of these services, that attending emergency departments (ED) (A&E) is only needed in the case of a medical or trauma related emergency. At a West Yorkshire level it is recognised that this may mean that the current number, type and location of emergency departments could change. This links to our Urgent and Emergency care transformational programme.
- Acute paediatrics workstream which has a vision to promote the best healthcare for Children and Young People in West Yorkshire through the provision of innovative, high quality, integrated and sustainable services in an appropriate environment that is as close to home as possible, allowing them to fulfil their potential and supporting the best health and wellbeing outcomes. This has clear links to our Growing Up in Leeds transformational programme and the children and young people aspect of our urgent and emergency care transformational programme.

Appendix 12 shows the overall approach taken by NHS England for Specialised Commissioning in Yorkshire & Humber.

Future state

We are working actively with colleagues across West Yorkshire to ensure alignment with specialised commissioning. We are working with providers to see how to centralise provision of services into centres of excellence to enable further growth on a larger footprint. Specifically we are considering cancer care and other areas for LTHT, criminal justice support for LCH and low secure, eating disorders and peri-natal services for LYPFT. Current plans can be found appended to this document.

Issues and gaps

We recognise that the specialist commissioning aspect of the work is still in development and will have an impact on the development of local modelling and vision. Our local work has been shared with NHS England and this will be developed over the coming three months in joint discussion. Although the financial planning around this is not yet complete we have made some assumptions from the information NHS England has provided. We have worked with our providers to ensure that our planning assumptions are in line with theirs.

Outcomes

- People’s quality of life will be improved by access to quality services.
- Financial stability of the Leeds Health Economy.

- People will be involved in decisions made about them.

Measurement

- Securing additional years of life for your local population with treatable conditions.
- Increasing the number of people having a positive experience of hospital care.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Activities

We will do this by:

- Working with our providers to develop their specialised services for Leeds with the wider commissioning community.
- Providing system leadership.
- Developing the cancer centre.
- Working to integrate pathways locally and regionally.
- Exploring research opportunities with the universities.

Sustainability

To ensure our secondary care providers are sustainable over the long term we need to work with NHS England as the specialist commissioner so that we do not negatively impact on the viability of providers. We believe we can achieve this in an innovative way that will improve outcomes for the population of Leeds and support our providers to be centres of excellence for specialist services in West Yorkshire.

For all six characteristics

Governance

The development of the work will be governed and measured by the Transformation Board through the transformational programme structure. The HWB and the Overview and Scrutiny committee oversee this process. Where changes to services need public consultation this will take place. In addition, some of the work for the six characteristics will have some additional supporting governance:

Characteristic	Additional Governance process

Citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	through patient and public representation on patient advisory and liaison groups, and CCG boards and steering groups
Wider primary care, provided at scale	through each individual CCG and member practices
A modern model of integrated care	strategic discharge group and LTC Programme Board
Access to the highest quality urgent and emergency care	Leeds Strategic Urgent Care Board
A step-change in the productivity of elective care	cross-CCG group of commissioners and clinicians, with public health and finance support. Pathway redesign delivered through clinically chaired groups
Specialised services concentrated in centres of excellence	10 CCGs group at a West Yorkshire level

We will work to ensure that our commissioned services keep the public safe and that we and our providers learn from reviews such as Francis, Berwick and Saville to ensure that mistakes cannot happen again. We will work with our own staff and those of providers to ensure we apply the best practice in the management and development of all staff to achieve a high performing workforce that is flexible, responsive and proactive in its approach and ensure high levels of staff satisfaction. Working with the other CCGs in West Yorkshire and the LETB we will plan to have a skilled workforce now and in the future. We will link to the CQC if we have concerns about our providers.

Assumptions, dependencies and risks and their management

The transformation of existing methods of service delivery will place greater emphasis on the availability of community based support and care and less emphasis on the use of acute, urgent and long term care services. Key to this will be our economic modelling approach to track both incremental and step changes in activity and income arising as a result of transformation to inform the impact on providers and any necessary reprofiling of changes to allow the system to adapt in a stable way.

We will need to work in a way that ensures that the financial, legal and contractual frameworks are designed and implemented to commission integrated care. Additionally, providers will be incentivised to collaborate to design and deliver the holistic care models. This will include a commitment to the sustainability of the provider organisations who engage in developing integrated models of care where shifts of activity could have a destabilising effect.

Overall this will require new ways of working for not only commissioners and providers, but also for the public in how they interact with the health care system.

Commissioner

We are assuming that the dialogue with NHS England will be open and transparent, and so far this has been the case. There is obviously a risk that making changes to providers of local as well as specialist services may impact negatively on them as a viable organisation and we will make every effort to ensure that we work collaboratively to ensure that this is not the case.

Partners and providers

Increasing the support closer to home and in the community will also require commitment from all provider organisations including secondary care, mental health services and the third sector. Member practices and the wider primary care team will need to work together to ensure that changes happen in the community to allow new ways of delivery to happen.

Public and patients and carers

Patients and their carers need to be able and willing to take on a more proactive role to their care and some will need support to do this. We will also need to support members of the public to get in involved in the wider process of engagement and this will need innovative approaches to seek feedback from those who are traditionally seen as hard to reach.

Next steps

Developing the strategy to this point is only the start of the journey. We recognise that we cannot afford to keep doing what we are doing. By bringing together the transformational programmes we can deliver a model of care that is able meet our vision and improve quality for patients in terms of experience and clinical outcomes. We will focus on delivering through quality improvement, reducing variation and innovation as we know this will deliver better value for money.

There is lots of work already programmed over years one and two of the strategy timeline that will deliver improvements to the system that are transactional and will realise some of the changes we need to create the room to make future changes. Without these first steps we will not be able to prepare the system, and the users of the system, for the transformational changes we need. The most significant transformational impact will be seen from year three onwards. We need primary, social and community care to be expanding to allow care closer to home. The work will be driven and managed through the Transformation Board.

Although there is a clear structure in place, this does not mean that the process is static. Build/measure/learn feedback loops will always be in place ensuring that waste is kept to a minimum; local and national best practice will constantly feed into this process. This process will identify gaps and areas of opportunity and challenge.

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