The Leeds Teaching Hospitals NHS Trust

Alignment of Partnership Working Report
Public Board
26th November

Presented for:	Information
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Previous Committees:	Partnerships Steering Group 10th November

Freedom of Information Act (FOIA) Exemption	☐**YES** (restricted from the FOIA) ☒**NO** (available to the public under the FOIA)

Link to Strategic Objective	Partnerships – integration that adds value, with patients at the centre.
Link to Provider Capability Assessment	Strategy, leadership and planning
Link to CQC Well-led Statement	Partnerships and Communities
Regulatory Impact	N/A

Key points	**Purpose**
1. The Board is asked to note progress across the establishment of partnership governance, neighbourhood delivery plans, the waste reduction conference, system flow working, the Trust's anchor partnership role and the maturing of the Leeds Provider Partnership.	Information

Risk Appetite Framework			
Level 1 Risk	**Level 2 Risks**	**(Risk Appetite Scale)**	**Impact**
Workforce Risk	Choose an item.	Choose an item	Choose an item.
Operational Risk	Choose an item.	Choose an item	Choose an item.
Clinical Risk	Choose an item.	Choose an item	Choose an item.
Financial Risk	Choose an item.	Choose an item	Choose an item.
External Risk	Partnership Working Risk - We will maintain well-established stakeholder partnerships which will mitigate the threats to the achievement of the organisation's strategic goals.	Open	Operating within

1. Summary

This report provides the Board with an update on six connected areas of partnership delivery:

1. Development of internal partnership governance;
2. Progress and delivery plans for neighbourhood care;
3. Update on the annual waste reduction conference and its focus on partnerships;
4. Update of provider led system flow and escalation workshops and the role of the National Frailty Improvement Collaborative;
5. LTHT's role as an Anchor Partner;
6. Development of the Leeds Provider Partnership (LPP).

Together, these programmes are intended to make integrated working more practical by agreeing delivery plans towards shared population outcomes, improving clearer decision rights and coordinating deployment of Leeds resources. The Board is asked to note progress and support the continuation of partnership maturity and development.

2. Update

2.1 Establishment of Partnerships Governance

LTHT has established a two-tier internal governance model to provide clearer ownership, prioritisation and assurance for partnership delivery against our strategic objectives:

- **Partnerships Delivery Group:** brings together clinical and operational leads involved in neighbourhood transformation to develop pathway proposals, translate system strategy into plans, coordinate dependencies and maintain delivery oversight.
- **Partnerships Steering Group:** provides strategic direction, aligns activity with the Organisational Strategic partnership ambition, resolves barriers and escalates material risks or decisions through the appropriate executive routes.

The reporting mechanism for regular updates has been agreed to align directly to Board and is reflected in the updated Board Assurance Framework.

2.2 Delivering Neighbourhood Care across Leeds

The Leeds neighbourhood model is based on coordinating services across fifteen neighbourhoods and three multi-neighbourhood footprints, aligned to Primary Care Networks and Local Care Partnerships. It seeks to deliver coordinated, person-centred care close to home, reduce inequalities and organise specialist support around communities rather than organisational boundaries.

The initial priority cohorts for transformation are frailty, multiple long-term conditions (MLTC) beginning with diabetes, and the development of a Leeds-wide children and young people model. These priorities provide practical test cases for the wider governance, workforce, digital, estate and financial capabilities required for neighbourhood health. The approach is to use a consistent tiered model across different population cohorts starting from public health and prevention schemes progressing through to neighbourhood-based proactive care, coordinated multi-neighbourhood multi-disciplinary team (MDT) support, and then city-wide specialist coordination. A breakdown of current progress across priority areas can be found below:

2.2.1 Frailty – Community Comprehensive Geriatric Assessment and Neighbourhood Alignment

The community Comprehensive Geriatric Assessment (CGA) pilot commenced in October 2026 in East Leeds. The pilot is testing how MDT assessment can be delivered closer to home, bringing together community, primary care and specialist expertise around the needs of people living with frailty to prevent deterioration and keep patients out of hospital. Importantly, the pilot is intended not only to test the clinical model, but also the practical enablers required for wider neighbourhood delivery, including referral and identification routes, MDT working, specialist input, workforce, information sharing and the interface between neighbourhood and acute services. Learning from the pilot will inform the development of a common tiered frailty offer and the potential for wider rollout across Leeds during 2027/28. The pilot has been operational since October and will run for a 10 week period with alignment of consultant job plans progressing against neighbourhood footprints.

2.2.2 Diabetes MDT and MLTC

Alongside the frailty work, the diabetes MDT is being tested in South Leeds with the intention of becoming operational in January 2027. The MDT will test how primary care, community and specialist diabetes expertise can work together around people with more complex needs, moving specialist support closer to neighbourhood teams and enabling earlier, more coordinated intervention. The objective is that the initial diabetes model provides the foundation for a broader approach to multiple long-term conditions (MLTC), progressively incorporating weight management and developing towards a more integrated cardio-renal-metabolic model. The learning will be used both to refine the diabetes pathway and to understand the workforce, data, clinical governance and specialist interface required to support a scalable neighbourhood model for people with multiple long-term conditions. The wider delivery plan anticipates scaling the diabetes model across South Leeds before subsequent expansion across the city. Our current commitment includes aligning consultant job plans to the neighbourhood team and MDT working.

2.2.3 Children and Young People

A third area of focus is the development of the Children and Young People (CYP) neighbourhood health model. LTHT has been working with the West Yorkshire ICB and wider Leeds partners to define the programme of work and ensure that the role of acute and specialist paediatric services is designed into the emerging model from the outset. The Leeds ambition is similar to adults, with a more integrated, multidisciplinary approach that provides earlier intervention, reduces fragmentation and enables health, education, social care and voluntary sector partners to work as one team around children, young people and families.

Within LTHT, initial engagement with the Children and Young People's Board has been used to identify where neighbourhood working could make the greatest difference and to connect the programme with paediatric clinical and operational leaders. Rather than simply transferring existing hospital activity into community settings, the work is considering how specialist expertise can be used differently to strengthen prevention, build capability outside hospital and redesign pathways around families. Initial opportunities identified include constipation and continence, asthma, allergy, diabetes, sleep, obesity, dermatology/eczema, children with complex needs and mental health or neurodiversity needs, alongside opportunities for home-based and community models of specialist care.

The next phase is being developed jointly with the ICB and wider partners to define and prioritise a coherent programme of work, bringing together existing initiatives rather than

establishing a series of disconnected pilots. An LTHT CYP neighbourhood group is being convened with paediatric and community colleagues to articulate the Trust's ambition, identify the pathways with the strongest case for change and agree which proposals should be taken forward through the Leeds neighbourhood programme.

2.2.4 Draft Delivery Plan

Table 1 – Leeds Neighbourhood Priority Delivery Plans

Workstream	By Mar 2027	2027/28	2028 Onwards
Diabetes / MLTC *(starting in the South Multi-neighbourhood)*	Agree tiered diabetes model and service specification; commence implementation.	Scale diabetes model to South Leeds Multi-neighborhood and incorporate weight management at neighborhood level; expanding the multi-morbidity approach.	Scale diabetes model to the city of Leeds, scale the metabolic model to South Leeds multi-neighborhood and incorporate CVRM approach into the neighborhood level. Scale to city over 2 further years refining a broader cardio-renal-metabolic / MLTC model operating consistently with local tailoring.
Frailty *(starting in the East Multi-neighbourhood)*	Agree common tiered frailty offer and specialist interface. Testing of CGA in East Leeds multi-neighbourhood	CGA roll out city wide, proactive frailty and reactive/recovery routes consistently connected to neighbourhood teams.	Evidence-led scale of interventions that reduce avoidable deterioration and dependency.
Children & young people	Agree CYP neighbourhood architecture and priority cohort(s).	Test integrated model with families across health, care, education and community support.	Scale proven model with consistent tiers and local adaptation.

Alongside development of the clinical models, LTHT has worked with partners to identify a pipeline of up to 19 potential neighbourhood estate sites, which has been submitted to NHS England as part of capital planning. Feedback is awaited on whether any capital funding will be made available in the current financial year, which would provide an opportunity to accelerate development of elements of the neighbourhood infrastructure while the longer-term service and estates model continues to develop.

2.3 Waste Reduction Conference and Productive Partnerships

LTHT held its eighth annual Waste Reduction Conference on 5th November 2026 and for the first time, the event was opened to system partners with representation from primary care, community services, the voluntary, community and social enterprise sector, mental health, the West Yorkshire Integrated Care Board and the Department of Health and Social Care. This broadened the conference from an internally focused productivity event into a

practical forum for identifying efficiency opportunities that sit across organisational boundaries.

The conference focused on Productive Partnerships and explored where pathway redesign, diagnostic demand optimisation, community delivery, procurement collaboration and better use of collective capacity could reduce avoidable activity and expenditure while improving patient experience. The next step is to convert the strongest opportunities into a prioritised action pipeline with named owners, baselines, anticipated financial or capacity benefit, partner dependencies and an agreed governance route. This will allow the Partnerships Steering Group to distinguish opportunities that can be progressed within LTHT from those requiring Leeds-wide or West Yorkshire collaboration.

2.4 Strengthening System Flow Partnerships

A series of workshops have been led by the partnerships team bringing together system partners to review governance arrangements and challenge each other on opportunities to improve system flow. Partners agreed that the principal weakness was not the absence of forums, but limited visibility of pressures across organisations, inconsistent escalation thresholds and insufficient clarity about which decisions could be taken through operational, tactical, strategic or formal incident routes.

The work has brought together agencies from across the system to review escalation arrangements, identify shared risks and develop a practical system decision-management tool. The tool records each potential surge action, the trigger for use, decision authority, owner, mobilisation time, intended impact, dependencies, trade-offs, review point and de-escalation plan. It is designed to support existing governance and formal emergency preparedness, resilience and response arrangements, not replace them.

The next step in the work programme is to refine the minimum viable action set, confirm formal sign-off, establish ownership of the daily process and incorporate learning into the Leeds winter operating model.

2.4.1 Influence of National Frailty Collaborative

Linked to above, Leeds has been selected to participate in the National Frailty Improvement Collaborative, a 12-month learning and improvement programme which will help test new ways of working to aid system flow. The local focus is deliberately narrow: frailty-attuned care during the first 72 hours following hospital attendance, followed by home-based assessment and neighbourhood-enabled discharge once acute care has added value.

This complements the LTHT frailty strategy and the Leeds tiered frailty model, and it offers a mechanism to connect strong existing components, including acute frailty, same day emergency care, Home Ward, discharge improvement and community frailty support, into a more reliable end-to-end pathway. Immediate work includes pathway mapping, agreeing baseline measures, establishing the improvement team and testing changes that reduce delay, duplication, deconditioning and avoidable time in hospital. Frailty improvement groups will be established in November to run for a 12-month period.

2.5 Anchor Partner Role

LTHT continues to develop its role as an anchor institution through active participation in the Leeds Anchors Network. The Trust is a signatory to the Leeds Anchors Partnership Agreement and contributes to the network’s procurement, climate and communications workstreams, with work under way to strengthen representation on employment. LTHT has

completed three organisational progression reviews, most recently in 2026, covering employment, procurement, environment and assets, service delivery, and corporate and civic leadership. The current priority is to use this framework more systematically to translate LTHT's scale as a major employer, purchaser and estate owner into measurable social value, including inclusive employment, local and responsible procurement, environmental sustainability and action to reduce health inequalities.

2.6 Development of the Leeds Provider Partnership (LPP)

The Leeds Provider Partnership (LPP) is intended for providers to take greater collective responsibility for population outcomes, inequalities and the use of health and care resources. Its purpose is to reduce fragmented pathways, repeated hand-offs and avoidable demand while retaining clear statutory and organisational accountabilities.

Following discussion at the West Yorkshire System Leadership Executive, the immediate approach has been reframed. Work on a lead-provider contractual model and the associated detailed due diligence has been paused. This reflects the current national and regional position and the ICB view that the benefits of Place Provider Partnerships should not depend on a new contract. The immediate priority is therefore shared transformation priorities, collective plans, robust joint decision-making and clear accountability rather than a new contractual form.

During December 2026 to March 2027, partners will refresh the existing alliance agreement, establish a monthly LPP Executive Group, develop the proposed LPP Board/Joint Committee and agree a common Leeds provider plan. The intention is to have a minimum viable partnership model in place by April 2027, capable of being tested and strengthened through 2027/28. This will include clearer accountability for programmes, pathways and neighbourhoods, supported by aligned performance and assurance arrangements.

The LPP will then work with the ICB to define its influence over Leeds resources, including the Leeds NHS allocation, relevant Council and community resources, Section 75 and Better Care Fund arrangements, and key workforce, asset and information dependencies. This does not assume that every service will be integrated or every budget pooled; collective action will be used where it can achieve materially better outcomes or value. For 2027/28, partners will develop a collective plan around a small number of shared priorities, initially it is expected to focus on neighbourhood health, outpatient transformation and community mental health, distinguishing organisational actions from those requiring partnership delivery.

2.6.1 Implications for LTHT

- LTHT should continue to shape the LPP as a mechanism for collective delivery, while preserving clear Board oversight of statutory, clinical, financial and fiduciary responsibilities.
- No undefined service scope, historic liability or accountability should transfer without matching authority, information, capability and risk protection.
- Out-of-hospital services are the minimum planning assumption, but dependencies with acute pathways must be explicitly designed rather than separated administratively.
- The shadow year should use real decisions and reporting to evidence whether the partnership can plan, manage performance, govern transformation and assure risk collectively.

3 Quality and Performance Implications

The programmes are intended to improve continuity, reduce avoidable hand-offs, support earlier intervention, shorten unnecessary hospital stays and align specialist input with neighbourhood care. The quality risk is that change is scaled before models, workforce, clinical accountability, information flows and outcome measures are sufficiently mature. Each pilot therefore retains defined inclusion criteria, clinical oversight, agreed measures, equity analysis and a clear decision to scale, adapt or stop.

4 Financial Implications

No new financial approval is requested through this report. Most neighbourhood transformation is expected to begin through redesign and better integration of existing resources, with targeted catalyst funding where necessary. Benefits will not all be immediately cash-releasing because provider costs are partly fixed and value may arise in a different organisation from the investment. The LPP work must therefore develop transparent baselines, aligned planning, benefits realisation and risk/gain arrangements before any pooled or population-based funding mechanism is adopted.

5 Risk

The report is within LTHT's open appetite for external partnership working and does not materially change current risk exposure. The external environment supports collaboration, although partner readiness and system uncertainty require phased delivery, clear governance and formal approval gateways. Controls include the Partnerships Delivery Group and Steering Group, defined pilot measures and clinical oversight, due diligence, reserved matters and Board approval at each material gateway.

6 Communication and Involvement

Delivery has been developed through cross-partner governance involving NHS providers, primary care, Leeds City Council and voluntary and community partners.

7 Impact on Equality & Health Inequalities

Equality and Health Inequality Impact Assessments have been held by the ICB and wider city-wide transformation changes will be before implementation.

8 Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

9 Recommendation

The Board is asked to:

- note the establishment of internal partnership governance to route partnership prioritisation, delivery oversight and escalation;
- note the development of the annual Waste Reduction Conference into a system-facing Productive Partnerships event and support progression of the resulting opportunities through a prioritised action pipeline;
- note progress in neighbourhood delivery, including the community CGA and diabetes MDT pilots, and Leeds' participation in the National Frailty Improvement Collaborative;
- note LTHT's continuation as an anchor institution in Leeds;

- receive assurance on the system decision-management approach, while noting the remaining implementation, ownership and evaluation requirements; and
- support the LPP direction of travel, noting that material transfers of scope, resources, functions or risk will require due diligence, defined gateways and formal approval, with a further Board update at the next material gateway.

10 Supporting Information

Not applicable.