Public Document Pack

HEALTH AND WELLBEING BOARD

Meeting to be held in Council Chamber, Civic Hall, Leeds on
Monday, 6th December, 2021 at 12.30 pm
(Pre-meeting for all Board Members at 12.00 p.m.)

MEMBERSHIP

Councillors
S Arif S Golton N Harrington
M Harland
F Venner (Chair)

Representatives of Clinical Commissioning Group
Dr Jason Broch – Chair of NHS Leeds Clinical Commissioning Group
Tim Ryley – Chief Executive of NHS Leeds Clinical Commissioning Group
Dr Alistair Walling – Chief Clinical Information Officer of Leeds City and NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Victoria Eaton – Director of Public Health
Cath Roff – Director of Adults and Health
Sal Tariq – Director of Children and Families

Representative of NHS (England)
Anthony Kealy - NHS England

Third Sector Representative
Pat McGeever – Health for All

Representative of Local Health Watch Organisation
Dr John Beal - Healthwatch Leeds

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

Safer Leeds Joint Representative
Jane Maxwell – Safer Leeds
Supt. Richard Close – West Yorkshire Police

Representative of Leeds GP Confederation
Jim Barwick – Chief Executive of Leeds GP Confederation

Agenda complied by: Harriet Speight
Governance Services 0113 37 89954

Note to observers of the meeting:

To remotely observe this meeting, please click on the 'View the Meeting Recording' link which will feature on the meeting's webpage (linked below) ahead of the meeting. The webcast will become available at the commencement of the meeting.

https://democracy.leeds.gov.uk/ieListDocuments.aspx?CId=965&MId=11452&Ver=4

Please Note - Coronavirus is still circulating in Leeds. Therefore, even if you have had the vaccine, if you have Coronavirus symptoms: a high temperature; a new, continuous cough; or a loss or change to your sense of smell or taste, you should NOT attend the meeting, stay at home, and get a PCR test. For those who are attending the meeting, please bring a face covering, unless you are exempt.

A G E N D A

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

4			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration (The special circumstances shall be specified in the minutes)	
5			**DECLARATION OF INTERESTS** To disclose or draw attention to any interests in accordance with Leeds City Council's 'Councillor Code of Conduct'.	
6			**APOLOGIES FOR ABSENCE** To receive any apologies for absence	
7			**OPEN FORUM** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations or to ask questions on matters within the terms of reference of the Health and Wellbeing Board. No member of the public shall speak for more than three minutes in the Open Forum, except by permission of the Chair.	
8			**MINUTES** To approve the minutes of the previous Health and Wellbeing Board meeting held 16 September 2021 as a correct record.	9 - 14
9			**TRAUMA AWARENESS, PREVENTION AND RESPONSE** To consider the report of the Leeds Trauma Awareness, Prevention and Response Steering Group that sets out the Leeds ambition, approach, progress to date and next steps in developing our Compassionate Leeds: Trauma Informed City. This is a long-term ambition and will need a strategy and plan to reflect that need to keep our focus on this area for the next decade.	15 - 42

10			**AN UPDATE ON THE PHYSICAL ACTIVITY AMBITION** To consider the joint report of the Director of Public Health and the Director of City Development that provides an update on the development of the Physical Activity (PA) Ambition for Leeds which is being led by Active Leeds and Public Health together with partners across the city. The report builds upon previous items covering the Physical Activity Ambition presented at the Health and Wellbeing Board in December 2018 and October 2020.	43 - 60
11			**REVIEW OF THE LEEDS HOUSING STRATEGY** To consider the report of the Head of Housing and Homelessness that informs the Board of the review underway to produce a new 5 year Leeds Housing Strategy. The strategy review will be underpinned by the Council's 3 strategic pillars including the Health and Wellbeing Strategy. Consultation and engagement on the housing strategy priorities will take place during November and December, with a view to finalising the updated strategy by April 2022.	61 - 76
12			**BETTER CARE FUND PLAN** To consider the report of the Director of Pathway Integration (NHS Leeds CCG) and the Deputy Director of Integrated Commissioning (Leeds City Council) that seeks sign off from the Leeds Health & Wellbeing Board for the Leeds BCF Plan 2021/22.	77 - 128
13			**LEEDS HEALTH AND CARE FINANCIAL REPORTING AT END OF SEPTEMBER 2021 (M6 2021/22)** To consider the report of the Leeds Health and Care Partnership Executive Group (PEG) that provides the Health and Wellbeing Board with an overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide financial report.	129 - 136

14			**CONNECTING THE WIDER PARTNERSHIP WORK OF THE LEEDS HEALTH AND WELLBEING BOARD** To consider the report the Chief Officer, Health Partnerships, that provides a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.	137 - 142
			ANY OTHER BUSINESS	
16			**DATE AND TIME OF NEXT MEETING** The next meeting will be held Tuesday, 22nd February, 2021 at 1:30 p.m.	
			<u>Third Party Recording</u> Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

HEALTH AND WELLBEING BOARD

THURSDAY, 16TH SEPTEMBER, 2021

PRESENT: Councillor F Venner in the Chair

Councillors S Arif, S Golton, M Harland and N Harrington

Representatives of Clinical Commissioning Group
Tim Ryley – Chief Executive of NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Victoria Eaton – Director of Public Health
Chris Dickinson – Head of Commissioning, Children and Families

Third Sector Representative
Pat McGeever – Health for All
Darren De Souza - Touchstone
Pip Goff – Forum Central

Representative of Local Health Watch Organisation
Hannah Davies – Chief Executive of Healthwatch Leeds

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

Representative of Safer Leeds
Supt. Richard Close – West Yorkshire Police
Jane Maxwell – Area Leader, Communities, Leeds City Council

Representative of Leeds GP Confederation
Gaynor Connor – Leeds GP Confederation

1 Welcome and introductions

The Chair welcomed all present and brief introductions were made.

2 Appeals against refusal of inspection of documents

There were no appeals.

3 Exempt Information - Possible Exclusion of the Press and Public

There were no appeals.

4 Late Items

There were no late items.

5 Declaration of Interests

There were no declarations of disclosable pecuniary interests or other interests.

6 Apologies for Absence

Apologies for absence were received from Dr John Beal, Anthony Kealy, Jason Broch, Cath Roff, Sal Tariq, Jim Barwick, Sara Munro and Dr Alistair Walling. Chris Dickinson, Gaynor Connor and Cathy Woffendin were in attendance as substitutes.

7 Open Forum

There were no matters raised on this occasion.

8 Minutes

RESOLVED – That the minutes of the meeting held 29th April 2021 be approved as an accurate record.

9 Joint Strategic Assessment 2021 - Draft Summary Report

The Head of Intelligence and Policy (Leeds City Council) submitted a report that sets out progress in producing the 2021 Joint Strategic (Needs) Assessment (JSA). The production of a JSA on a three-yearly cycle is a joint responsibility between Leeds City Council and the NHS Leeds CCG to inform the Health and Wellbeing Strategy. Specifically, the JSA aims to shape priorities, inform commissioners, and guide the use of resources as part of the commissioning strategies and plans for the city, by understanding the core drivers of health and wellbeing.

Mike Eakins, Intelligence and Policy Officer at Leeds City Council provided an overview of the analysis set out within the report, the key findings and policy implications. It was also confirmed that the JSA would become a 'real-time' database of information, in recognition of the constantly evolving health and care system.

Members discussed a number of matters, including:

- *Identifying successful approaches.* Members sought more information about the findings relating to successful action taken to narrow the gap. Members noted the benefits of licensing policy, with selective licensing schemes providing further opportunities to identify needs through the selective licensing scheme in some of the most deprived areas in the city.

- *Wider determinants of health.* Members noted that wider determinants of health will have the greatest effect on the key challenges identified within the JSA in the long term, and therefore require commitment from all health partners across the city as Team Leeds through commissioning and multiagency response to issues such as housing. The Chair requested that an item to consider the quality of provision of housing across the city be scheduled for a future meeting.
- *The role of the Board moving forward.* Members noted that the assessment provides an extensive evidence base, and that the subsequent strategies and action plans will be presented to the Board at a later stage. Members also suggested introducing a number of bold ambitions to future plans, such as to reduce the rate of long-term conditions in the city, and noted that upcoming plans and strategies must align with existing work streams and strategies across the health and care system.

RESOLVED – That the contents of the report, along with Members' comments, be noted.

10 How health and care organisations are working together in Leeds to tackle health inequalities

The Leeds Tackling Health Inequalities Group submitted a report that proposes that the Health and Wellbeing Board holds the health and care system to account in making changes to tackle health inequalities and requires organisations to publicly say what has happened and what more is to be done.

Hannah Davies, Chief Executive of HealthWatch Leeds, introduced the report and presented the health inequalities toolkit developed for health partners to support decision making, along with three commitments for the Board to sign up to:

1) To hardwire a focus on the role of health and care in addressing health inequalities, as the future Place Based Partnership's (PBP – working title) overriding purpose, and through our organisations, Population Boards, Care delivery and Service delivery group, and wider partnerships, requiring them to publicly say what has happened and what more is to be done.
2) To lead the culture shift that is required throughout organisations (at all levels) and commit to going further and faster than nationally mandated activity to tackle health inequalities, using the Tackling Health Inequalities Toolkit as a foundation to support our partnership's individual and collective efforts.
3) To consistently establish robust and regular peer to peer support / challenge, including working with the Communities of Interest Network and Allies, to share commonalities and hold each other to account.

RESOLVED –

a) That the contents of the report, along with Members' comments, be noted.
b) That the Boards commitment to the three recommendations set out above be noted.

11 Digital Exclusion

The People's Voices Group submitted a report that reflects on recommendations made a year ago by the People's Voices Group and views of health and care providers about how they have addressed this key inequalities and access issue.

Hannah Davies, Chief Executive of HealthWatch Leeds, introduced the report and provided an update on the progress against the recommendations one year on from the original Health Inequalities report. Anna Chippindale, HealthWatch Leeds, presented the key themes from service user feedback for digital inclusion within the last 6 months.

Members provided updates on the action taken to progress the recommendations and the challenges faced within their organisations, including:

- Members recognised that digital innovation requires buy in from the entire organisation – from leadership to frontline care providers and service users.
- Leeds Community Healthcare (LCH) have introduced as part of initial assessment a question - 'how would you like me to work with you?' – so that service users can request digital contact, face-to-face, or a combination of the two.
- All health partners had introduced training schemes for service users in the community. It was suggested that digital skills sessions could also be delivered within a health care settings or pharmacies.
- Members noted the additional barrier and training need for people with English as an additional language.
- During pandemic, Leeds and York Partnership Foundation Trust (LYPFT) delivered handheld devices to service users within mental health hospitals to ensure that they maintained contact with friends and families. Community Committees also allocated funding to provide equipment to vulnerable families.

RESOLVED –

a) That the contents of the report, along with Members' comments, be noted.
b) That Members link with their Communities of interest ally in preparation for this item to understand how digital exclusion is currently impacting on the communities they work with.

12 Leeds BCF End of Year 2020/21 Template and iBCF Update

The Chief Officer, Resources & Strategy, Adults & Health (Leeds City Council) and the Head of Planning & Performance (NHS Leeds CCG) submitted a report that sought sign off from the Health and Wellbeing Board of the End of Year 2020/21 Template.

RESOLVED – That the Board agreed to sign off the Leeds BCF End of Year 2020/21 Template attached as Appendix 1 and noted the benefits and outcomes of the additional iBCF funding.

13 For information: Connecting the wider partnership work of the Leeds Health and Wellbeing Board

The Board received, for information, the report of the Chief Officer, Health Partnerships, that provides a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.

RESOLVED – That receipt of the report be noted.

14 For information: Leeds Routine Enquiry: GPs and Health Practitioners in 8 GP Practices in Leeds- Evaluation Report 2019

The Board received, for information, the report of the Safer Leeds Safeguarding & Domestic Violence Team, that report that explores data on the short term impact for victims where GPs and Health Practitioners, who have access to a specialist worker, have proactively screened female patients over the age of 16 for Domestic Violence and Abuse (DV&A).

RESOLVED – That receipt of the report be noted.

15 For information: Putting people at the heart of decision-making - update on progress in planning the Big Leeds Chat 2021

The Board received, for information, the report of the People's Voice Group that outlines the plans for Big Leeds Chat 2021.

RESOLVED – That receipt of the report be noted.

16 Date and Time of Next Meeting

The next meeting will be held Wednesday 8th December 2021 at 2.00 p.m.

(Pre-meet for Board Members at 1:30 p.m.)

17 Any Other Business

The Chief Officer and the Chair thanked Holly Dannhauser for her support over the years to the Board and the broader work of the Health Partnerships team, and wished her luck in her future ventures.

Leeds Health and Wellbeing Board

Report authors: Jane Mischenko,

Kathryn Ingold, Julie Longworth, Emmerline Irving, Carrie Rae

Report of: Leeds Trauma Awareness, Prevention and Response Steering group

Report to: Leeds Health and Wellbeing Board

Date: 6 December 2021

Subject: Trauma Awareness, Prevention and Response

Strapline: Leeds a compassionate city: building a trauma informed city together

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

Our ambitious vision is for Leeds to be a trauma informed city that works to prevent the conditions that lead to trauma and responds compassionately and swiftly whenever trauma, or risk of trauma is present.

Trauma is identified as one of 3 key priorities within the recently refreshed Future in Mind: Leeds strategy (2021-26), as requiring a real focus, as signed off by the Health and Wellbeing Board, (April, 2021).

Leeds recognises the importance of adopting a life course and intergenerational approach in this work, as reflected in our Leeds All Age Mental Health Strategy (2020-25).

This paper sets out the Leeds ambition, approach, progress to date and next steps in developing our Compassionate Leeds: Trauma Informed City. This is a long-term ambition and will need a strategy and plan to reflect that need to keep our focus on this area for the next decade.

The CCG and Local Authority are combining resources, to create the children and families' trauma service; this will be a key enabler in the ambition to be a trauma informed city.

A Children and Families multi-agency steering group currently drives this programme and a steering group focusing on adults who have lived experience of ACEs and trauma is to be established. These two steering groups will regularly come together, and the output of the recent trauma informed city event will help shape their strategy and programmes.

Leeds is working closely with the West Yorkshire Adversity, Trauma and Resilience programme to ensure we maximise the impact of our respective work for the benefit of children and families, and adults with lived experience of trauma.

As referenced above in Leeds we are working closely with our partners in West Yorkshire and have included an additional paper to be read in conjunction with the Leeds paper. The West Yorkshire paper and the recommendations within it are borne out of the West Yorkshire (WY) Adversity, Trauma and Resilience Strategy Board, WY ATR Network and WY Consortium for Adults Facing multiple Disadvantage.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the ambitious vision and scope of the Leeds work
- Recognise progress to date in Leeds
- Note proposed next steps in Leeds
- Recognise the synergy of the WYICS programme and benefit of working together

1. The Leeds Approach

This paper sets out plans to prevent, raise awareness of and respond to Adverse Childhood Experience's (ACEs) in Leeds, in an ambitious vision to ensure Leeds is a trauma informed city. The paper explains what ACEs are, the prevalence in Leeds, how they can lead to trauma and why it is important to reduce them and their affect. The paper also sets out our proposed approach in working towards achieving this ambition.

> *Our ambitious vision is for Leeds to be a trauma informed city that works to prevent the conditions that lead to trauma and responds compassionately and swiftly whenever trauma, or risk of trauma is present.*

Three senior responsible officers representing the NHS, children's social care and public health, have committed to reducing the prevalence of ACEs in Leeds and to identify and respond swiftly to those experiencing trauma. A children and families multi-agency steering group has been set up to drive this work forward. Public Health has published a report outlining prevalence of ACEs in Leeds. Plans are in place to establish a multi-agency steering group for adult survivors of ACEs.

A Trauma Informed Movement / network is being created in Leeds, to harness and connect the knowledge, expertise, and experience within the city. This began with a digital conference held on 4th November. Over 440 people registered, with the majority contributing and engaging throughout the day and expressing a keen interest in being involved in future developments. This acts as a catalyst for a wide range of partners to work together to raise awareness of the impact of Childhood Adverse Experiences (ACEs), to prevent trauma and to identify and respond early and swiftly to those experiencing trauma.

The CCG and Local Authority Children and Families Directorate are combining resources (existing and new), to create the children and families' trauma service; this will be a key enabler in the ambition to be a trauma informed city.

2. Background information

The Leeds Children and Young People's Plan 2018-2023 is the shared vision for everyone working with children and young people in Leeds. The Plan sets out our vision for Leeds to be the best city in the UK for children and young people to grow up in, and to be a Child Friendly city. Becoming a trauma informed city is the next step and will build on the Leeds approach to work in a restorative way with children and families.

There is already significant work taking place in Leeds across different services, settings and communities. This was recently demonstrated by the West Yorkshire Integrated Care System (WYICS) commissioned mapping exercise. Leeds had a rich return from across statutory and voluntary sectors of work already underway. However, we recognise that the people taking forward this excellent work aren't always aware of their peers' work and are not connected to them.

In a city as large and complex as Leeds there is a real benefit in bringing together our efforts in a connected movement under a trauma informed framework.

3. Main issues

3.1 What do we mean by Adverse Childhood Experiences?

It is useful to set out briefly what we know about Adverse Childhood Experiences (ACEs) before moving on to our shared definition of trauma. There is increasing recognition of the impact ACEs can have across the life course in terms of health, education and social outcomes as illustrated in diagram 1.

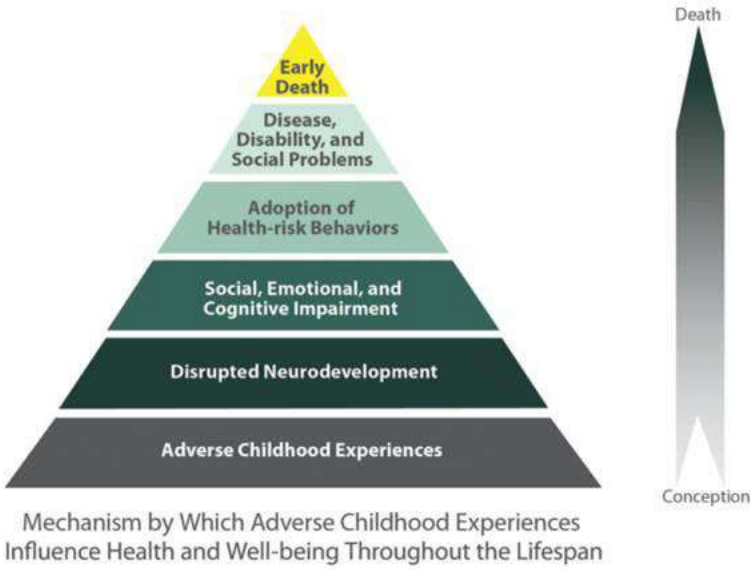


Figure 1: Centre for Disease Control and Prevention.

ACEs are understood as a set of ten traumatic events or circumstances occurring before the age of 18 that have been shown through research to increase the risk of adult mental health problems and debilitating diseases (see diagram 2, below). Five ACE categories are forms of child abuse and neglect, which are known to harm children and are punishable by law, and five represent forms of family dysfunction that increase children's exposure to trauma (EIF, 2020).

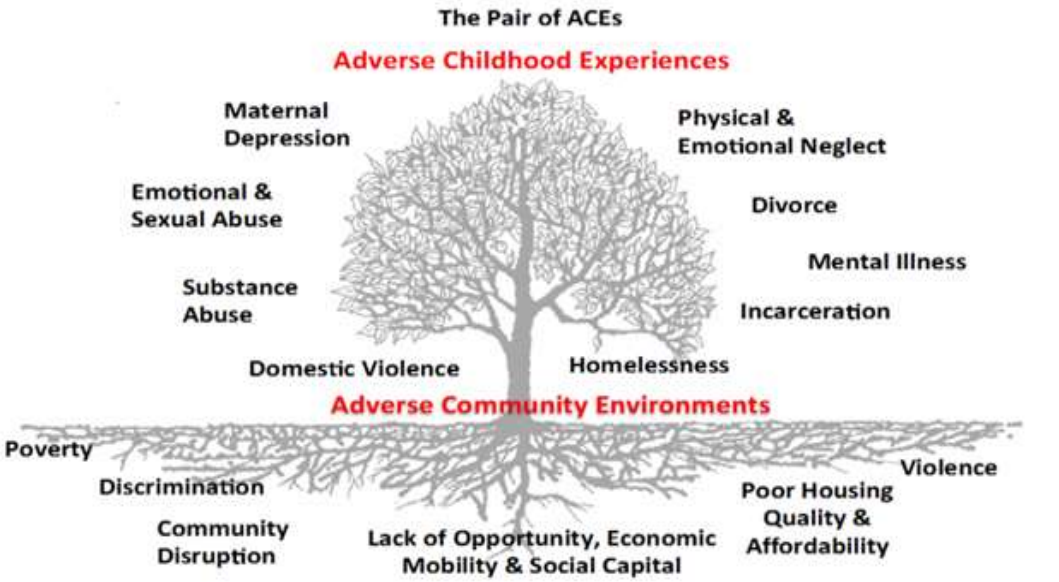
It is important however to acknowledge that there are limitations that exist in developing a response to ACEs; for example:

- Estimates of the prevalence of ACEs in childhood are imprecise (good data is missing).
- A focus purely on the original ten ACEs to the exclusion of other factors risks missing children who also need help. Key other negative circumstances in childhood are poverty, discrimination, persistent bullying, low birth weight and child disability. For example, studies show that low family income may be a

stronger predictor of poor physical health outcomes than many of the original ACE categories (EIF, 2020).

- For those who are poor, isolated, or living in deprived circumstances, there is an increased likelihood of ACEs and an amplification of their negative impact.
- There is a concern and risk that a deterministic interpretation of ACEs is taken, which omits recognition of the protective factors and strengths that mitigate poor outcomes.

Figure 2 overleaf illustrates the relationship between ACEs and adverse community environments; all of these will be factored into the Leeds approach.



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Figure 2

The terms ‘adversity’ and ‘trauma’ are often interchangeably used by professionals. Whilst adversity describes the situation and experience that a person has, trauma refers more commonly to the impact it has on their mental, physical, and developmental health.

Poor outcomes are not predetermined and are influenced by the balance of protective factors; they can be ameliorated with appropriate support and environments that build resilience in children affected by adversity, who are at risk of trauma.

3.2 What do we mean by a trauma?

The Leeds trauma working group particularly likes the Young Minds (2019) definition below, as a working definition of what we mean by trauma.

We all face emotionally challenging situations during our childhood and adolescence. For some people the environments they grow up in, the people they relate to, and the experiences they have are adverse, and have a potentially traumatic and lifelong impact on their development, physical and mental health, and ultimately their way of life. Adverse Childhood Experiences (ACEs) are defined as highly stressful events or situations that occur during childhood and/ or adolescence. It can be a single event or incident, or prolonged threats to a child or young person's safety, security, or bodily integrity.

3.3 Strategic fit

The Leeds Children and Young People's Plan and its underpinning strategies together with national drivers provide the clear strategic context for this area of work.

There is a range of work being delivered that has an implicit aim of reducing the risk of ACEs and resultant trauma. The Leeds Best Start Plan is one such example; this is a broad preventative programme from conception to age 2 years. This aims to ensure a good start for every baby, with early identification and targeted support for vulnerable families, early in the life of the child. This is a progressive universal approach. In the longer term, this will promote social and emotional capacity and cognitive growth and aims to break inter-generational cycles of neglect, abuse and violence.

The overall outcomes for the programme are:

- Healthy mothers and healthy babies at population and individual level
- Parents experiencing stress will be identified early and supported
- Well prepared parents
- Good attachment and bonding
- Development of early language and communication

The refreshed Future in Mind: Leeds strategy (2021-26) sets out the continued drive to improve children and young people's social, emotional and mental health (SEMH) outcomes. It has a particular focus on reducing health inequalities and identifying ad responding to trauma is one of the key priorities. Priority 5 of the Future in Mind: Leeds strategy is to reduce the impact of trauma:

'We will recognise the impact adverse childhood experience can have on mental health across the life course and will focus on establishing a clear offer and response to childhood trauma.'

The revised Early Help strategy (2020) provides structure and context to this work and is promotes a partnership approach to recognise the needs of children young people and families as early as possible, and so prevent escalation to statutory intervention –the *right conversation* with the *right people* at the *right time.*

The current Early Help review is building on and growing the Early Help strategy through the development of more streamlined integrated and accessible services.

The Leeds All Age Mental Health Strategy (2020-25) provides the opportunity to make further progress collaboratively taking a life course approach and recognised the intergenerational aspect of trauma and the importance of ‘Think Family, Work Family’.

This programme also aligns with and will contribute to delivering many of the overarching strategies and plans in the city such as – Leeds Health & Wellbeing Strategy (2016-21), Leeds Inclusive Growth Strategy (2018-23), Leeds Children’s Poverty Strategy (2019-22).

The programme is also crucial to deliver the left shift ambition and commitment to address health inequalities.

Our Leeds programme is a key component of a wider system ambition, the West Yorkshire Integrated Care System (ICS) Aversity, Resilience and Trauma programme.

3.4 ACEs in Leeds

Modelling done as part of the Children’s Commissioner’s local vulnerability profile for Leeds estimates:

- 33580 (19.8%) children and young people are estimated to live in households with any of the so called 'toxic trio' (i.e., domestic violence, parental mental health, and parental substance abuse).
- 1994 (1.2%) children and young people are estimated to live in households with all 3 of the so called 'toxic trio'.

The inter-relation between deprivation and vulnerability can be demonstrated by the higher proportions of children within the Leeds social care system who live in the most deprived areas. The following statistics are taken from a snapshot on 31st March 2020 where there were 3,623 Children in Need, 590 on a Child Protection Plan and 1,346 Children Looked After:

- 57.6% of children subject to a child protection plan live in the most deprived decile, compared to 8.3% in the top 5 deciles combined (based on Index of Multiple deprivation)
- The same pattern in seen in terms of the number of children looked after, with 59% living in the most deprived decile, 12% in the second most deprived, 7.8% in the third, and 14.9% from the fourth to tenth combined.

3.5 Leeds existing offer

In addition to prevention, Leeds takes a nurturing and relationship-based approach in recognising and responding to trauma. There is a strong practice principle of working with children and families, rather than doing for, or to. There are examples of excellent practice across the partnership in the city. However, whilst, there are some excellent programmes of work and some very robust and evidence-based services, these are not comprehensive, or currently configured to work most effectively together as a unified Leeds system. There are known gaps in both capacity and the completeness of the offer, particularly in the delivery of early help (before children become part of the statutory system).

3.6 What we need to do

When the original ACE study (Felitti, et al, 1998) was first published, the authors concluded that comprehensive strategies, involving universal, selected and targeted interventions, were necessary to prevent and reduce ACEs. These strategies included intensive home visiting interventions for vulnerable families, school-based programmes aimed at preventing health-harming behaviours, and targeted psychotherapeutic treatments, designed to help children and parents cope with ACE-related trauma (a comprehensive list of evidence based approaches can be found in EIF, 2020).

Adopting support through a trauma informed lens can contribute to a greater understanding of the reasons underlying some children's difficulties with relationships, learning and behaviour and lead to better outcomes. (Education Scotland)

We need to ask: Not what is wrong with you? But rather: **What happened to you?** And: **What needs didn't get met?**

A public health approach in local communities and settings is recommended to tackle ACEs, building on the evidence of what works to improve outcomes for children (EIF, 2020). Both Leeds and West Yorkshire and Harrogate Integrated Care System are taking this approach.

This needs to include a system-wide focus on the negative impact of childhood adversity and understanding of prevention and protective factors, with workforce practice, services, commissioning, and leadership, all aligned in a commitment to identifying and meeting the needs of the most vulnerable families.

3.7 Key Actions

A children and families multiagency steering group is established; this is focusing on work to develop the trauma informed movement, oversee the trauma service development and support working groups to deliver action initially around workforce development and trauma informed education settings.

Leeds is also working to develop a local place-based strategy alongside the WY&H ICS programme strategy, to align and ensure synergy, whilst also reflecting the distinct needs of the city. Leeds is also working with the ICS programme to bid for additional funding to support development in this area.

A digital event, **Compassionate Leeds: Developing a Trauma Informed City Together** took place 4th November. Over 440 delegates registered with most attending all, or part of the day and many requesting to view the recordings of the key-note presentations and workshops. The recordings, insights and ideas gathered from the event will help shape the strategy and the development of additional working groups. Many who attended are coming forward to be involved in the work.

An adult steering group (lived experience of ACEs and trauma) is forming soon, and the two steering groups will regularly connect.

There's a recognition of both the importance of developing our workforce to understand and take a trauma informed approach, and for the need to be mindful of and to support our staff's health and wellbeing. This recognises that many of our workforce may have experienced adversity; this maybe as a result of adverse childhood experience, or more recently the impact of the pandemic.

The integrated trauma service for children, will be developed to help underpin the trauma informed movement and to provide access to expertise and direct therapeutic support.

In addition there is the opportunity of Leeds and Bradford's recent successful data acceleration bid to focus on connecting data across the partnership to support early identification of children and families needing support.

4.0 Health and Wellbeing Board governance

Consultation, engagement and hearing the citizens' voice

Colleagues in the city have reviewed existing local and national reports to understand people's experience of trauma and what needs to improve. Some of the key headline messages are:

- Children often felt anxious, scared, depressed and ashamed, with many believing that the problems at home were their fault.

- Children report trying to shield and protect younger siblings.
- This insight report found that feeling listened to is particularly important to people who have experienced trauma.
- Evidence tells us that involving children and young people in their care and in the development of service increases safety and leads to improved access and experience.

There is a commitment to work with children and families and those with lived experience in the development of our strategy, programme, events and services. This has recently demonstrated in our November launch event, where presenters, workshop facilitators and delegates included those with lived experience of trauma. Initiated at the event there is work under way to create a common language and charter for trauma informed practice, led by those with lived experience.

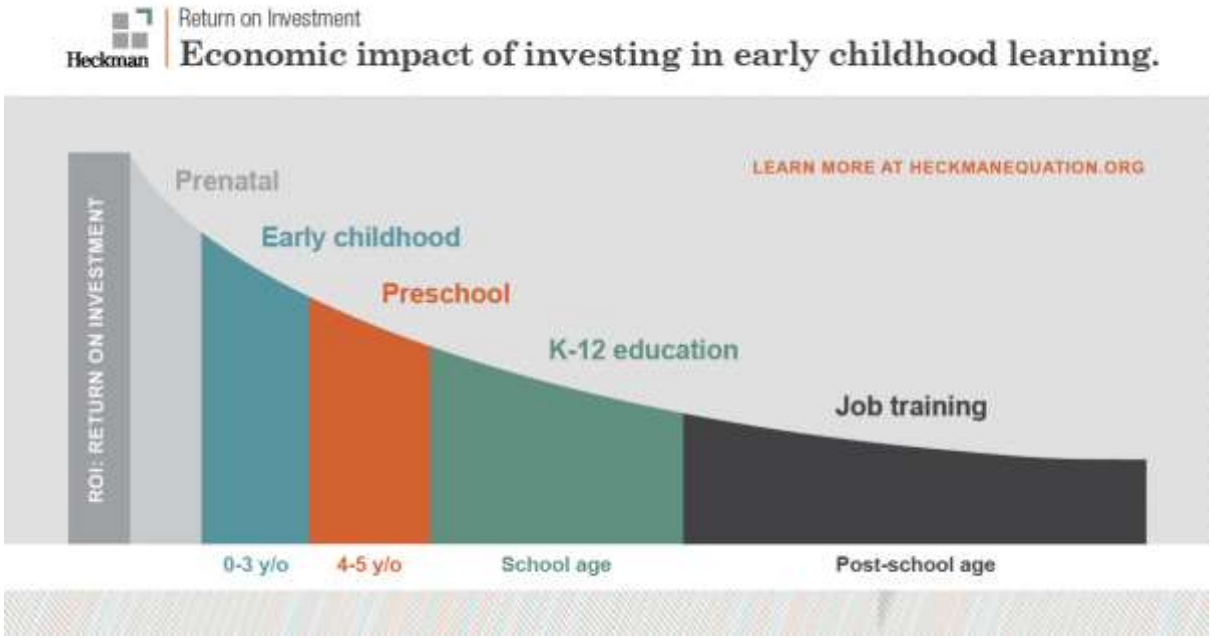
5.0 Equality and diversity / cohesion and integration

Childhood trauma can be exacerbated (as well as caused) by experiences of prejudice such as sexism, homophobia, racism and disablism. This prejudice not only intensifies the trauma they have faced, but discrimination, stigma or social marginalisation means they are also more likely to have only limited access to support and treatment. The Leeds approach recognises this as reflected in including adverse community experiences alongside the ten original adverse childhood experiences.

6.0 Resources and value for money

Professor James Heckman, Nobel Prize Laureate in Economics, through his research shows that quality early child development is essential for better education, health and economic outcomes for a whole population (see graph overleaf, which demonstrates the

return on investment).



The **cost of late intervention is estimated to be £16.6 billion a year** (in England and Wales); while not all late intervention is avoidable, there are considerable resources being spent tackling issues that could have been dealt with sooner and at less cost to the individual and to services (Early Intervention Foundation (EIF), 2016). There is local data that confirms this in children and young people who have been placed out of area; deep dives of 3 individuals illustrate how earlier integrated intervention could have prevented significant escalation of need in these children (report pending, 2021).

A recent Lancet article identifies that programmes to prevent ACEs and moderate their effects are available: Rebalancing expenditure towards ensuring safe and nurturing childhoods would be economically beneficial and relieve pressures on health-care systems.

Evidence from UK and international contexts suggests that failing to help young people recover from harm and trauma can mean that problems persist and/or worsen in adulthood, creating higher costs for the public purse (EIF, 2016; Kezelman et al, 2015).

6.1 Legal Implications, access to information and call In

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

6.2 Risk management

The Steering group(s) are responsible for owning any risks identified through the programme planning process, and to work collaboratively to develop proposals for mitigation and resolution.

7.0 Conclusions

Our ambitious vision is for Leeds to be a trauma informed city that works to prevent the conditions that lead to trauma and responds compassionately and swiftly whenever trauma, or risk of trauma is present.

Trauma is identified as one of 3 key priorities within the recently refreshed Future in Mind: Leeds strategy (2021-26), as requiring a real focus, as signed off by the Health and Wellbeing Board, (April, 2021).

Leeds recognises the importance of adopting a life course and intergenerational approach in this work, as reflected in our Leeds All Age Mental Health Strategy (2020-25).

This paper sets out the Leeds ambition, approach, progress to date and next steps in developing our Compassionate Leeds: Trauma Informed City. This is a long-term ambition and will need a strategy and plan to reflect that need to keep our focus on this area for the next decade.

The CCG and Local Authority are combining resources, to create the children and families' trauma service; this will be a key enabler in the ambition to be a trauma informed city.

A Children and Families multi-agency steering group currently drives this programme and a steering group focusing on adults who have lived experience of ACEs and trauma is to be established. These two steering groups will regularly come together, and the output of the recent trauma informed city event will help shape their strategy and programmes.

Leeds is working closely with the West Yorkshire Adversity, Trauma and Resilience programme to ensure we maximise the impact of our respective work for the benefit of children and families, and adults with lived experience of trauma.

8.0 Recommendations

The Health and Wellbeing Board is asked to:

- Note the ambitious vision and scope of the Leeds work
- Recognise progress to date in Leeds
- Note proposed next steps in Leeds
- Recognise the synergy of the WYICS programme and benefit of working together

9.0 Background documents

None

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?

A key priority in the Future in Mind: Leeds strategy is to reduce health inequalities – this is a priority in itself as well as an underlying key principle to be applied to all other priorities. This will take into account a need for proportional universalism – targeting resource to the communities that need it most.

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

The strategy includes the further development of services in response to need and demand, driving down waiting times and increasing access.

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

Addressing problems early in the life of the child and the problem helps to reduce costs further on in life and reduces the impact on adult's services later in life. Proportional universalism e.g. targeting resource to where it is needed first will improve outcomes and long-term costs.

Future challenges or opportunities

There is a clear opportunity to work together across the partnership, with local communities, particularly those with high need to build on existing partnerships across the system.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 **(please tick all that apply to this report)**	
A Child Friendly City and the best start in life	✓
An Age Friendly City where people age well	
Strong, engaged and well-connected communities	✓
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	✓
A stronger focus on prevention	✓
Support self-care, with more people managing their own conditions	
Promote mental and physical health equally	✓
A valued, well trained and supported workforce	✓
The best care, in the right place, at the right time	✓

The impact of COVID and increase in demand for children and young people's mental health services is likely to pose a challenge.

Additional Paper A: Background: West Yorkshire Adversity Trauma and Resilience Programme

Purpose of the paper

This paper sets out the system case and focus to prevent, or reduce the impact of Adversity, trauma and multiple disadvantages for the population of West Yorkshire.

The aim of the paper is to brief and secure the support of senior leaders across Leeds and should be read in conjunction with the Leeds: A city-wide response to Adverse Childhood Experiences: Taking a Trauma informed Approach

The paper and the recommendations within it are the result the West Yorkshire (WY) Adversity Trauma and Resilience (ATR) Strategy Board, WY ATR Network and WY Consortium for Adults Facing Multiple Disadvantage

The paper describes a coproduced approach to support all five places/districts to be trauma informed and sets out the case for change for a joint ambition to ensure WY is a Trauma Informed and Responsive System by 2030.

The WY Programme is jointly delivered by the West Yorkshire Health & Care Partnership and West Yorkshire Violence Reduction Unit. Sharing a common commitment with the Leeds City Wide response and with all partners across the system to prevent harm and improve the wellbeing of our population, with a particular concern for those who are most vulnerable, facing multiple difficulties, complex needs and childhood trauma. In order to deliver on this commitment a joint West Yorkshire Adversity, Trauma and Resilience programme.

Summary Overview

Children and Young People who experience adversity and trauma are at high risk of; poor physical/mental health and emotional wellbeing, substantive increases in adopting anti-social and health-harming behaviours, including serious violence, poor attendance/exclusion at school and decreased educational attainment.

Adults who face multiple disadvantages as a result of trauma and adversity are 4 times more likely to become an alcoholic, 15 more times likely to commit suicide, 3 times more likely to be absent from work and 3 times more likely to experience depression.

To improve outcomes for the physical, mental health and wellbeing of the people that live in West Yorkshire we need to work together to prevent trauma and adversity and mitigate existing harm across the lifecourse and while fully eradicating trauma remains unlikely, actions to strengthen community resilience and assets may partially offset their immediate harms.

There has never been a better time to prioritise the prevention of risk factors on health and increase protective factors as there is now with the ongoing pandemic.

People are making the connections between the determinants of health and poor outcomes, including the impact on adversity and trauma, not just for young people, but for our babies who have been born during the pandemic and in lockdown, through to adults and older people that have been experiencing substantial isolation.

To deliver our agreed ambition our approach is for all organisations and system leaders to work together as trauma and adversity cannot be prevented and responded to by one sector.

<u>we want to:</u>

- Prevent adversity and trauma across the life course.
- Respond to trauma and adversity that already exists, mitigating harm where possible.
- Facilitate an integrated trauma-informed and responsive system that enables all children and young people, including those with complex needs to thrive.
- Build and strengthen resilience assets and protective factors for individuals and communities
- Reduce risks and improve outcomes for those who experience adversity and trauma
- Ensure CYP can develop meaningful relationships with experienced professionals, who will champion on their behalf placing them at the centre of care, coordinating services around the child & family
- Provide senior clinical leadership across the system, strategic oversight, embedded reflective practice, specialist input and psychosocial interventions.
- Reduce inequalities that contribute to adversity and trauma and inequalities caused by adversity and trauma
- Ensure an understanding of adversity and traumatic events and the impact they have on an individual, their life chances and opportunities.
- Develop our response to adversity, trauma, and complex needs in this window of opportunity to build back better and fairer and minimise harm caused by COVID -19 and associated measures.

Underpinning our work is the principle that the voice of our population and communities is at the heart of everything we do, and we have developed a Community Action Collective, to ensure continued engagement and involvement. The Collective will deliver several

outputs including co-creation/co-design of the WY programme, curriculum, delivery of training, community events, and development of an Engagement, Involvement and Co-production Plan to inform the implementation of the framework and the WY 2022-2030 Strategy.

To achieve system, change we have to ensure that we are working at the right level within the system, building strong relationships with partners as the foundation, driven by local, national and international evidence, and policy. Building on the current practice already developed across all the places in West Yorkshire through the West Yorkshire Adversity Trauma and Resilience Network and the WY Consortium for Adults Facing Multiple Disadvantages.

The Network/Consortium have over 150 members including people with lived experience, with wide representation across sectors including but not limited to: early years and early help, commissioners, primary care, Acute Trusts, Mental Health Trusts, local authorities, education, educational psychologists, safeguarding, police, youth justice, housing, voluntary and community organisations. The role of the Network/Consortium is to steer the programme of work, test concepts and pilots, share practice and develop opportunities for system wide approaches.

<u>Current Pilots and subgroups include but not limited to:</u>

- Trauma Informed Training: WY Police, WY Housing Providers, Primary Care
- Trauma Informed Organisations: South and West Yorkshire Mental Health Foundation Trust, Bradford University,
- Trauma Informed Schools
- Adversity Trauma and Resilience Navigators: Calderdale and Huddersfield Foundation Trust

We are now working with colleagues and thematic experts to the develop the WY Adversity, Trauma and Resilience Strategy 2022 – 30. This Strategy will be coproduced with our population and we will launch as part of our 2nd annual 3-day knowledge Exchange due to take place in April 2022.

The knowledge exchange will also provide the opportunity for colleagues to access workforce development and training opportunities and there will be a focus on lived experience and coproduction.

I am proud to be the Senior Executive Lead for this important programme of work and as system leaders we are committed to ensure West Yorkshire is a trauma informed and responsive system by 2021 and implementing the recommendations from the three reports.

<u>To reach our vision we will work towards:</u>

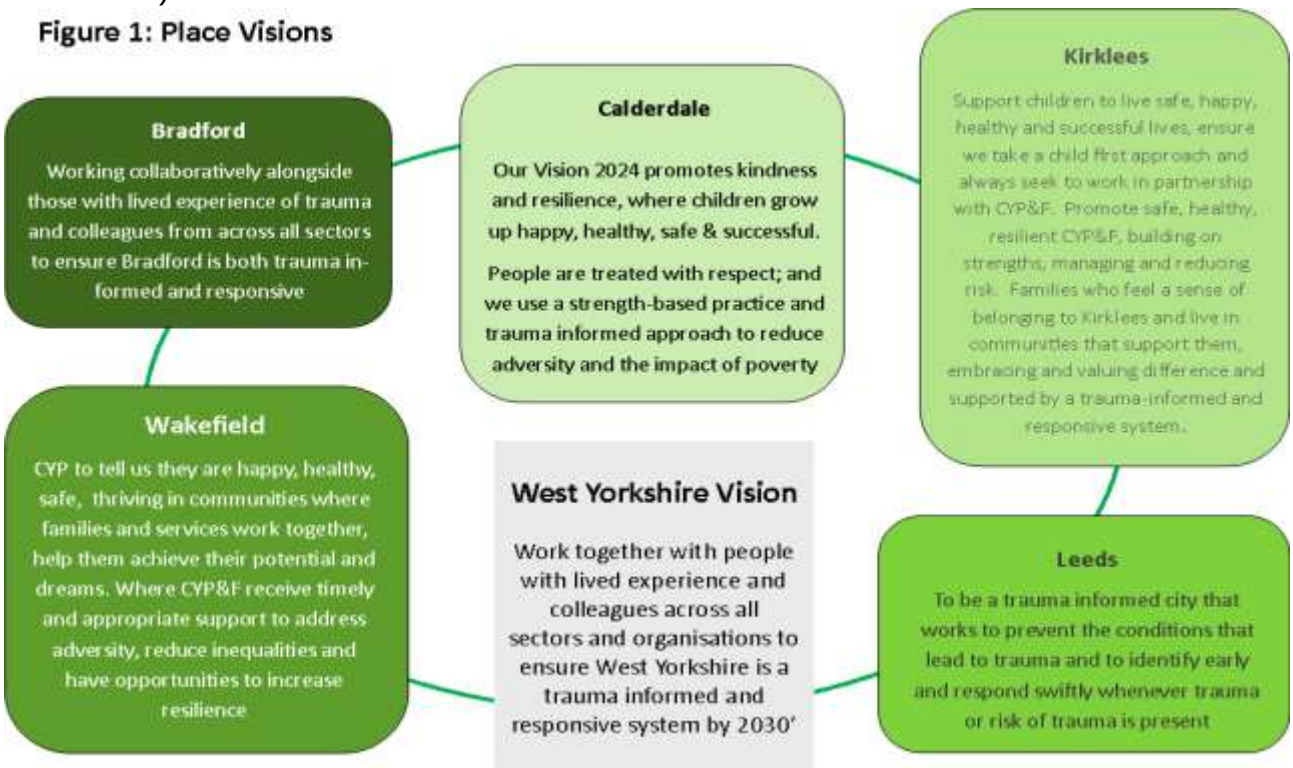
- Reducing trauma, adversity and building resilience for the whole population of WY, particularly children and young people and adults who are vulnerable and experiencing complex needs
- Supporting and strengthening community services for those with complex needs that are currently not being met
- Ensuring all people living and working in WY have access to and receive integrated support from a range of professionals across health, mental health, education, social care, youth justice, the police, and the voluntary sector to ensure that their needs are met in a coordinated way.

<u>The WYATR Programme will:</u>

- Support all place strategies and plans to be trauma informed and responsive by 2030.
- Embed a multi-sector and system trauma-informed approach with a coordinated, cross-system strategy, aligned policies, practices and services for supporting and building resilience.
- Utilise evidence and embed knowledge of trauma and adversity across all sectors
- Ensure all organisations across WY are trauma Informed and responsive
- Recognise / respond to the needs of the workforce (particularly those repeatedly responding to trauma).
- Collaborate across all sectors to ensure services are accessible and appropriate
- Partner, empower, educate and co-produce with our communities

The WYATR programme and vision are supported by our system leadership teams (see Section E3) and each of our5 districts visions as set out below:

Figure 1: Place Visions



As a system we are committed to investing in additional support for the most vulnerable people with complex needs.

This includes responding to need, intervening early, and strengthening our communities by reducing risk, building protective factors, resilience assets and social capital which may reduce immediate and long- term harm. To do this effectively we are working to understand current need across our system and numbers of people facing adversity, including evidence of the impact of adversity and trauma, as well as what works to prevent/mitigate harm, build resilience and ensure services are trauma-informed and formulation-driven.

West Yorkshire Adversity, Trauma and Resilience: Meeting our ambition

Responding to the needs of our population: What we already know:

We have a population of 570,000 children and young people in West Yorkshire and Harrogate, with a significant number of young people impacted by varying and increasing adversity and trauma, a snapshot of this can be seen below. We will identify exact numbers for our priority cohorts in Year 1 through our mapping and data work across West Yorkshire. As we are working collaboratively across the system, with all places and sectors, we will achieve and exceed the target set, supporting, working, and improving the outcomes of 6000 young people across West Yorkshire by 2030.

- West Yorkshire has seen a fall in the number of children entering the criminal justice system, but the offences committed are becoming more serious and more violent[1]
- Knife crime, crimes of violence against the person and gun crime have all been identified as a serious issue across WY, 42% of knife crime offenders are males aged 15-24, most knife crime offences take place in our poorest communities[2]
- The rate of children living in absolute low-income families per 1,000 children (0-15 years) is between 200 to 400 in WY[3]
- Much of the trauma experienced by young people in WY was found to be passed down through families, potentially exacerbated by gaps in service provision and unmet need including, dealing with intergenerational health inequalities[4]
- There are 987 looked after children in Bradford a 6.4% increase since 2017[5]

[1] CREST Report 2021

[2] VRU Needs Assessment January 2021

[3] 2019/20 Deprivation and Poverty CREST 202.

[4] Trauma and Unmet Mental Health Need CREST 2021

[5] Bradford JSNA

- First entrance rate into the Youth Justice System in Bradford is 455 per 10,000 10-17 population[6]
- 45% of Children Looked After (CLA) in Calderdale have mental health needs[7]
- Children were present at 34% of domestic abuse incidents in Kirklees and Calderdale[8]
- 50% increase in the number of children and young people demonstrating abusive behaviour towards their parents in Kirklees[9]
- In Leeds the inter-relation between deprivation and vulnerability can be seen in the fact that 57.6% of children subject to a child protection plan live in the most deprived decile, compared to 8.3% in the top 5 deciles combined[10]
- And that in Leeds 59% of children who are looked after living in the most deprived decile, 12% the second most deprived, 7.8% in the third and 14.9% from the fourth to tenth combined
- In Wakefield there were 640 children in care in April 2021[11]
- The predominant reason for children being looked after in Wakefield is abuse or neglect[12]

West Yorkshire Finding Independence: evidence and data 2020

It's estimated that almost 44,000 people across West Yorkshire are currently accessing homelessness, addiction, re-offending and mental health services. Nearly 7,000 access three or four services, equating to an average of 1,400 people in each LA area. WY-FI was only able to support 823 people over the life of the programme leaving a cohort of over 6000 still experiencing multiple disadvantages.

According to peer research and service use data; at least 20% of people experienced exclusion when trying to access services. Between 60% and 80% of WY-FI beneficiaries said they had a bad or very bad experience before accessing WY-FI Navigator support. In contrast, over 95% said they had good or very good experiences with navigator support.

People experiencing multiple disadvantages are likely to have lived or live in a deprived area and experienced poverty, poor education, unemployment, ill-health, unhealthy family situations, adverse childhood experiences, complex trauma and/or loneliness and isolation.

0% of Leeds areas are the most deprived - has the highest proportion of its areas in the most deprived. Bradford is ranked in the 20% most deprived areas in England, lower than any other LA area in West Yorkshire. receives the lowest rank amongst the five areas, placed in the most deprived 20% in England (IDACI 2015).

Wakefield reports 15.7% of the population are living in neighbourhoods that are amongst the top-10% most deprived in England.

---

[6] Bradford JSNA

[7] Calderdale JSNA

[8] Kirklees JSNA

[9] Kirklees JSNA

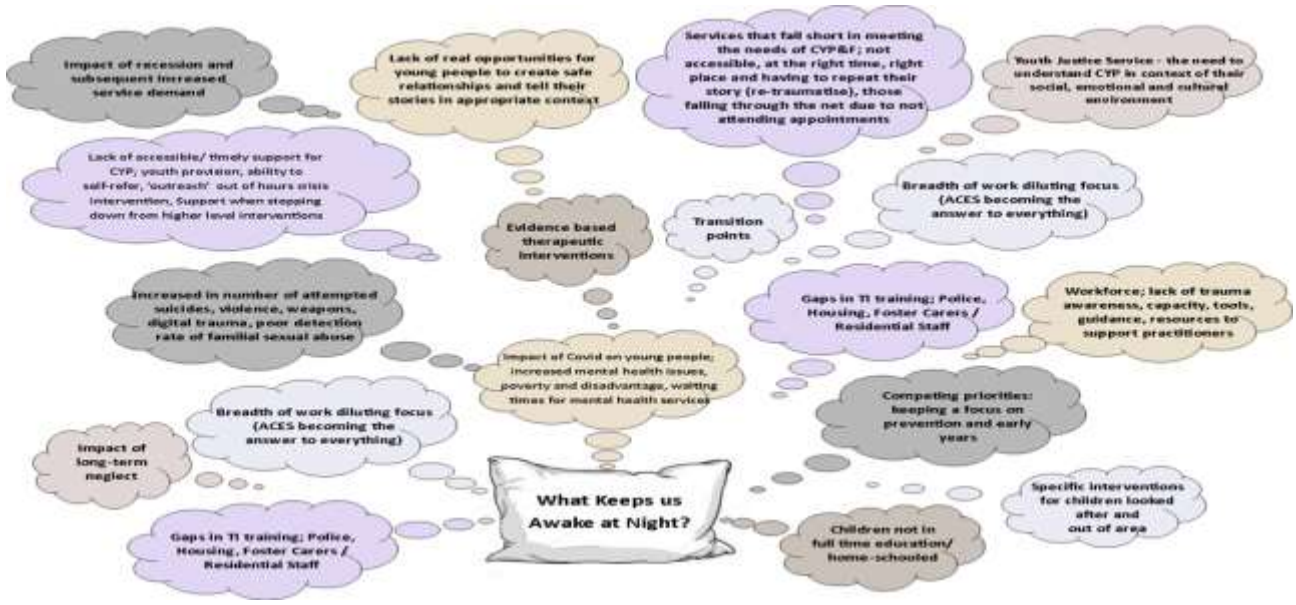
[10] Leeds PHE Improving Health Outcomes for Vulnerable Children and Young People with additional local data (2021)

[11] Wakefield Vital Signs Report April 2021

[12] Wakefield JSNA 2

Through our system partnership, over the next 8 years we will continue to develop the evidence base, undertake needs assessments and inequality impact assessments to continue to understand the needs of specific cohorts of our population with complexities and embed a culture change prioritising prevention and early intervention. To achieve this all partners, sectors and organisations must work collaboratively to support our most vulnerable people.

Figure 3: **What keeps us awake at night?**



Partnership working

Our ethos is to connect organisations and individuals in ways that make better care easier and use opportunities to make better connections and use our unique partnership assets to improve health and wellbeing. Working together we have the chance to create the conditions so that children get the best start in life and improve our population's chances of living a long and healthy life.

Key to our system approach and delivering our ambition by 2030 is the engagement of stakeholders, partnership working and building networks. Through the partnership the system wide trauma informed programme of work has been jointly led since June 2020.

We have an established WY Adversity, Trauma and Resilience Network with currently 150 members including people with lived experience. The network has a focus on adversity, trauma, and resilience from preconception to 25 years. The System Programme has also brought the West Yorkshire Consortium for Adults Facing Multiple Disadvantage into the governance Structure support out population from 18 onwards. Both groups have wide representation across sectors including but not limited to; early years and early help, commissioners, primary care, Acute Trusts, Mental Health Trusts, local authorities, education, educational psychologists, safeguarding, police, youth justice, housing, voluntary and community organisations. The role of the Network is to steer the programme of work, test concepts and pilots, share practice and develop opportunities for system wide approaches and working.

Our five places across WY are represented on the network and within each place integrated care partnerships are in place.

Partnerships have been established with colleagues with subject matter expertise and system leaders in adversity and Trauma, including Dr Warren Larkin, Consultant Psychologist and Catherine Knibbs, Online Harms & Cybertrauma Advisor, to support this work and we are working with a number of national and international networks to share practice and learning including

- Office of Health Improvement and Disparities
- International Trauma Informed Care Network
- NHSE/I Trauma Informed Community of Practice

The commitment to partnership working across the system and support to deliver the ambition is demonstrated through the pledges of commitment from system leaders and staff across WY of which we have over 100 (see Appendix A)

In March 2021 a WY&H 3-day ATR Knowledge Exchange was held across the system with over 1,500 attendees. The event workshops, led by specialists in the field including those with experience of trauma, highlighted how when organisations come together to support people at the right time in their life, they can support them better to lead a long, healthy life where possible free from the impact of trauma. There was an emphasis on how grassroots expertise can underpin the shifts in culture and practice needed to achieve our vision of an area which is trauma informed and responsive to people's needs.

Coproduction and Engagement

Underpinning our work is the principle that the voice of our population is at the heart of everything we do. At a system level across WY people have been involved in co-developing the framework response through the following:

WY&H Youth Collective: WY Youth Partnership Board who support us by being the voice of young people influencing and informing decision making, working jointly with, and feeding back on the work of the WYHHCP to locally led young people's groups and engaging with us on issues affecting the lives of young people. Our Youth Collective has identified key priority areas to work with us as; the direct and indirect impacts of Covid on CYP&F, reducing health inequalities and mental health, emotional wellbeing, and resilience, which have all been included as a focus of this EOI. A resilience workshop has been held with young people and our group has agreed to work with us in partnership to support resilience across WY. The Youth Collective will continue to work as a key partner in implementation of the framework and identifying quality improvements.

Commissioned insight and co-production: Crest Advisory were commissioned by the Partnership and the WY VRU to understand the root causes of serious youth violence and exploitation in WY. Engagement was undertaken with a diverse range of young people across WY with complex needs including from PRUs, the SEND cohort and youth offending teams. Recommendations from young people from the research included a need to.

- Address deprivation and socio-economic disadvantage
- Address trauma and mental health needs
- Address educational inequality
- Build supportive systems around young people
- Provide universal support, targeted support, and family-based support
- Provide school-based interventions

West Yorkshire Changing Systems and Integrating Care project will undertake system scoping and modelling to identify the:

- Enabling conditions and prerequisites, along with the barriers and detractors to progress.
- Value, advantages and disadvantages of adopting whole system approach.
- Evidence and Insight from existing good practice across West Yorkshire.

A response strategy has been produced with recommendations and options to build lasting system change, considering primary of place, system level actions and implementation and strengthening links with place, the project also included:

- WYH&CP Executive Summary & Final Report
- WY-FI Future Demand Paper
- WYH&CP Adults Services Mapping Summary
- WYH&CP CYP Services Mapping Summary
- WYH&CP Lived Experience Summary Narratives
- WYH&CP Equalities Impact Assessment
- Trauma Informed Practice – A Workforce
- Development Perspective

WY ATR Community Action Collective: A Community Action Collective is being established to ensure continued engagement and involvement of WY communities including CYP in implementing the framework response. The Collective will deliver several outputs including co-creation/co-design of the WY programme, curriculum, delivery of training, community events, and development of an Engagement, Involvement and Co-production Plan to inform the implementation of the framework and the WY 2022-2030 Strategy.

Each of our five districts have a wealth of expertise and experience in involvement, engagement, and co-production with CYP and families and existing local groups and mechanisms in place to ensure continued input into implementing the framework across each district; examples of these include.

- Parent and service user involvement in the SEND reform Deep Dive in Bradford
- Calderdale Children Safeguarding Partnership Young Advisors- views gathered from hundreds of young people across Calderdale on subjects including child exploitation and online safety which informs priorities, services, and prevention activity
- Kirklees Children in Care Council
- Leeds MindMate Ambassadors, Leeds Voice, and Influence team, who support a range of young people and parent/carer councils (including children in care and with SEND)

Wakefield's recent 'Build our Futures' summit which was attended by 86 CYP representing a diverse set of interests.

<u>Collaborative working and the governance</u>

Alongside formal governance we have achieved a coalition where all partners are bound together around a shared vision and purpose, creating the conditions for our ambition to become a reality.

A task and finish group was established in June 2020, with 30 members and has continued to be flexible to meet the needs of our population and partners to enable the beginning of a joined up, whole system approach.

From June – September 2020 extensive engagement was undertaken with system leaders, networks, and Boards to increase collaboration and partnership working including WY&HHCP System Leaders Executive & Clinical Forum, WY Leaders of H&WB Boards, Royal College of GPs Board, WY&H Mental Health, Learning Disabilities and Autism Board and Children's Lead Commissioners. This engagement successfully increased the partnership across the system resulting in the development of the WYATR Programme Steering Group, with a number of sub- groups for scoping and delivery.

In March 2021 the WYHHCP in partnership with the WYVRU developed and delivered a 3 Day Adversity and Trauma Knowledge Exchange with over 1500 attendees. The event was for all colleagues from senior leaders to staff working directly with people who have experienced adversity and trauma.

The 3 days provided the case for change and covered the growing evidence of the impacts of adverse and traumatic experiences throughout life and the importance of organisations working better together to prevent and mitigate the impact of adverse experiences. Day 3 of the event focused on lived experience, engagement, and co-production.

Since the event collaboration has increased both at a system and place, including

- Members of the Steering Group increased to over 150, prompting a full restructure of the programme and governance review.
- Agreement for the WY Multiple Needs Consortium to move into the WYHHCP under the WYATR Programme by September 2021
- Development of local partnerships e.g., Directors and Heads of Service across Kirklees
- Partnerships with experts and system leaders, to deliver masterclasses and support the continued development/delivery of the WYATR Programme and Strategy.

<u>Adversity, Trauma and Resilience (ATR) Programme Structure and Governance</u>

The Programme is led by the senior managers from the WYHCP Improving population Health Programme, CYP and family's programmes and the WYVRU. Kersten England CBE (Chief Executive of Bradford Council) is our System Executive lead and chairs the Adversity, Trauma and Resilience Strategy Board.

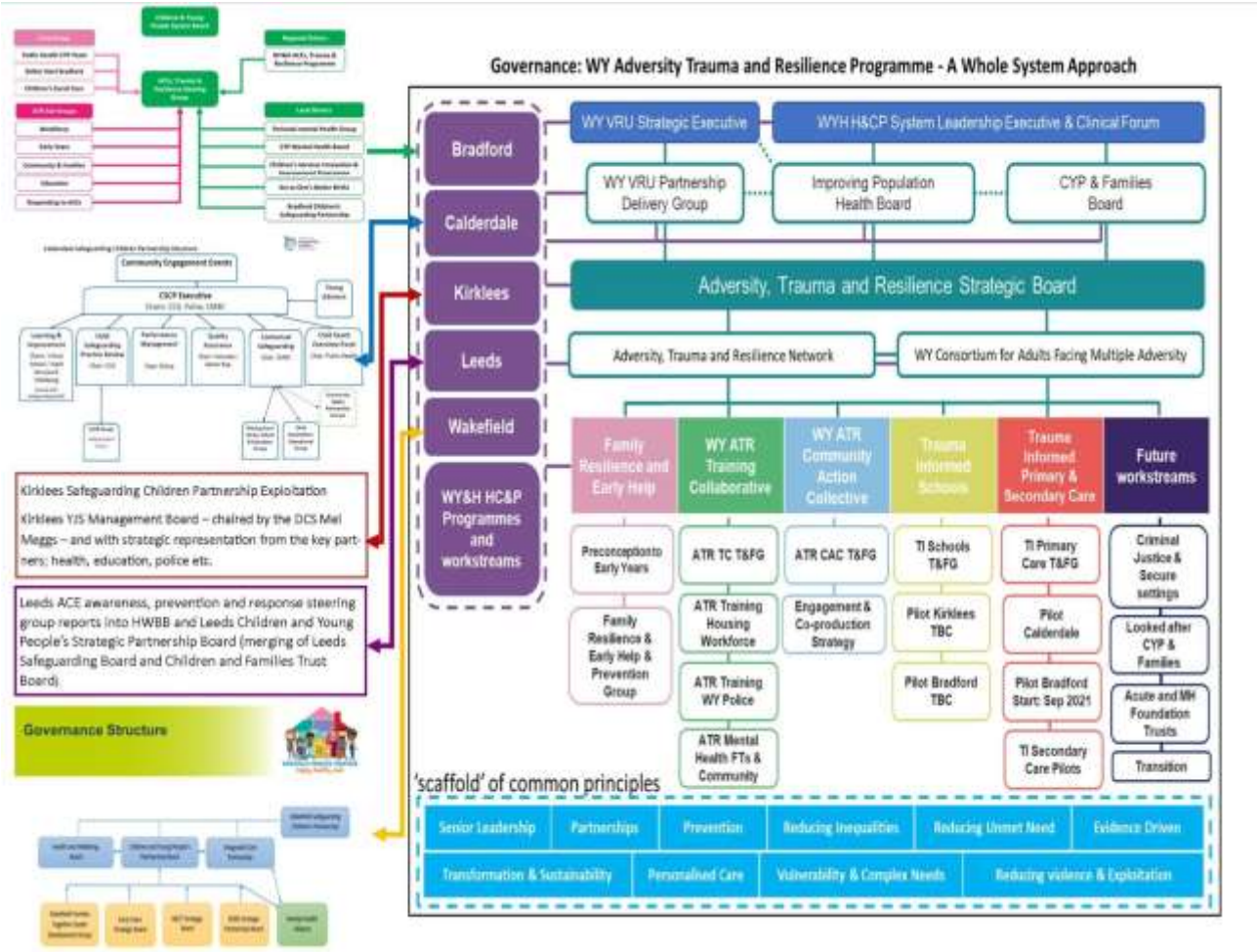
Overall responsibility for the success (monitoring, progress, performance against system agreed KPIs and evaluation) of the WYATR Programme sits with the WYHHCP and WYVRU as the lead organisations.

WYATR Strategy Board, formal decision-making group, will; manage any third-party providers, monitor, and mitigate slippage identified in the timeline and milestones, report and escalate risk through the governance structures of the WYHHCP System Leadership Executive, WYVRU Strategic Executive Group and via governance structures in each 5 places. The Strategy Board will delegate responsibilities and delivery to the WYATR Network and day to day decision making via the Senior Programme Managers.

<u>The structure of the programme includes</u>

- WYATR Strategy group
- WYATR Network with a focus on 0-25 (including members with lived experience)

- WY Multiple Needs Consortium 18+ (bimonthly) responding to the needs of our adult population, parents and carers experiencing multiple disadvantages and breaking the intergenerational cycle.
- Quarterly joint meetings to focus on transition (16 – 25yrs)
- Sub- groups for scoping and delivery



<u>Demonstrating impact and effectiveness</u>

WY will embed a sustainable programme of collaborative working and culture change, prevent and respond early to adversity and trauma, ensuring:

- all organisations across WY are trauma informed and responsive
- a workforce that is therapeutic, skilled, confident, trauma informed and responsive, where every interaction matters
- staff are trained to ask in a routine or targeted way about adverse and traumatic experiences as part of an appropriate assessment process
- support for CYP who experienced adversity/trauma may/may not yet have, however, their environment (social and economic) increases their level of vulnerability and risk; CYP who:
    - live in the most deprived areas,
    - live in areas with high prevalence of serious violence and crime,
    - are experiencing inequalities,
    - have learning disabilities /ADHD/ Autism/ SEND,
    - are adversely affected by covid-19 and measures
    - are vulnerable/at risk but don't meet thresholds for specialist support

Fundamentally our approach is relationship-driven and based on the assumption that with appropriate training, supervision and crucially, permission - all our staff can make a therapeutic impact. We recognise the strength of the working alliance, the compassion expressed and the trust that is cultivated between our staff and the young people being fundamental to the success of our approach.

Outcomes and Objectives (Also please see our Theory of Change at Appendix B)

We will work together to strengthen existing provision, intervene earlier in all pathways and services to deliver the following outcomes and more for the population of WY:

- improve physical/emotional wellbeing and reduced mental health concern,
- reduce high-risk behaviours, including serious violence and exploitation,
- reduce the number of people entering the youth justice system/secure settings
- increase educational attainment, attendance and reduce exclusions,
- Reduce the number of Children in Care
- increase aspirations, sense of belonging and purpose,
- ensure every interaction matter making the most of teachable moments,
- Increase protective factors through the development of trusted relationships, safe/secure psychologically informed environments, good quality housing/stable homes, friendships, and networks.

Monitoring, evaluating, and measuring effectiveness; To demonstrate the impact of the WYATR Programme we will:

- develop a system dashboard of KPIs against agreed objectives and outcomes
- Use a wide range of data sources and systematic collection of information, including magnitude, scope, characteristics, and consequences both direct and indirect, to produce a system, multi-sector profile of the prevalence and impact of adversity and trauma.
- Support/undertake annual needs assessments at system and place, to inform decision-making, service development and interventions to reduce and prevent adversity and trauma
- understand the nature and extent of adversity and trauma, including patterns and trends of risk and protective factors
- understand and respond to the Impact of Covid-19, increasing inequalities and demand on services
- Undertake internal and external evaluations,
- understand what works/doesn't work, where delivery can be accelerated and replicated across the system, capture evidence, share learning and best practice

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Gill Keddie/Judith Fox/Sue Haigh

Tel: 07891 276756

Report of: Director of Public Health and Director of City Development

Report to: Leeds Health and Wellbeing Board

Date: 6th December 2021

Subject: An Update on the Physical Activity Ambition

Strapline: 'Get More People, More Physically Active, More Often'

Comms & Engagement: Please provide 3 key points that you would want to communicate with the public about this paper / item for use on social media to promote engagement with this meeting.

Are specific geographical areas affected? If relevant, name(s) of area(s): Get Set Leeds Local in Priority Neighbourhoods	☒ Yes	☐ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This report provides an update on the development of the Physical Activity (PA) Ambition for Leeds which is being led by Active Leeds and Public Health together with partners across the city. The report builds upon previous items covering the Physical Activity Ambition presented at the Health and Wellbeing Board in December 2018 and October 2020. It includes the following information:

- Physical Activity Ambition – progress, agreeing the priorities and next steps
- Covid-19 Response
- Proposed Physical Activity Governance arrangements
- Exploring the role of system leaders around physical activity

Recommendations

The Health and Wellbeing Board is asked to:

- To note the progress presented and support the proposed next stage priorities of Active Environments and Active People - Reconditioning.
- Support the establishment of the Physical Activity Partnership Board as part of governance arrangements.
- Consider their role in realising a number of system leadership outcomes to support the achievement of the Physical Activity Ambition.

1 Purpose of this report

1.1 Provide an update on progress with the Physical Activity Ambition and the response to Covid-19. Proposes a focus in the next stage on the two priorities of Active Environments and Active People – Reconditioning.

1.2 Give an overview of the development of Physical Activity Partnership Board.

1.3 Explore the role of strong system leadership in developing the Physical Activity Ambition.

2 Background information

2.1 There is clear evidence that being active is essential for good physical and mental health and wellbeing. As well as being physically active, it is important that all adults and children minimise the time spent being sedentary for extended periods. Increasing physical activity levels has the potential to improve the physical and mental health and wellbeing of individuals, families and communities and reduce inequalities.

2.2 The ambition is for Leeds to be the most active city in England. This is outlined in the Leeds Health and Wellbeing Strategy 'Get More People, More Physically Active, More Often' and is a key component of reaching our vision to be a healthy and caring city where people who are the poorest improve their health the fastest.

2.3 Embedding physical activity into everyday life provides a unique opportunity to contribute to the three city strategic pillars of Inclusive Growth, Health and Wellbeing and Climate Change. This aligns with other key strategies such as Mental Health Strategy, Transport Strategy and developing the Local Plan. There is good evidence that the benefits of increasing physical activity are wide ranging including impact on employment and employability, promoting engagement and civic trust and reducing isolation. Realising the ambition to increase levels of physical activity has the potential to contribute to a healthier place, a greener city and a stronger local economy.

Physical activity levels have flattened off in recent years and have significantly reduced due to the impact of Covid-19. The most recent Active Lives survey shows the percentage of inactive adults in Leeds is 25.5%, 164,100 people aged 16+ are inactive in Leeds (May 2020 – May 2021). Inequalities have widened and lifestyle habits have changed – leading to less active and more sedentary hours. The "Build Back Fairer Covid-19 Marmot Review" highlighted that there are pre-existing inequalities in levels of physical activity related to the socioeconomic position and that more advantaged groups tend to have higher levels of physical

activity. Adults in higher occupational groups increased their levels of physical activity more than adults in lower occupational grades.

Many older adults were negatively impacted due to the lockdown with many aged 70 years+ shielding. The “Build Back Fairer Covid-19 Marmot Review” also found that lockdowns and social isolation were much more harmful to people without access to gardens and this will have impacted on levels of physical activity and wellbeing. It also pointed out that being active outside can have a more positive mental health impact than other kinds of exercise. It is evident that there are a range of inequalities in physical activity levels and action is needed to address these.

3 Main issues

3.1 Physical Activity Ambition – Further progress and agreeing the priorities

3.1.1 “Get Set Leeds” - As previously described to the HWB in October 2020, the development of the new PA Ambition began with a city-wide conversation ‘Get Set Leeds’ in January 2019. ‘Get Set Leeds’ was a proactive engagement campaign that encouraged a city-wide conversation about physical activity. It gave people a chance to their share ideas on what getting active meant to them and what might support them to move more. It focused on identifying assets, barriers and co-producing solutions. Get Set Leeds was the largest-ever study completed in Leeds around the importance of physical activity in the lives of over 4000 residents.

3.1.2 The four key messages set out below emerged from the study analysis by Leeds Beckett (Appendix A) University and have shaped the development of the Physical Activity Ambition:

- Most people want to be physically active but find it hard to be – motivation isn’t enough.
- People do not feel their environment makes it easy to be active, this includes having space to move and be active in, feeling safe in the places around us, access to transport and child-care, good air quality and local information.
- Inactive people want to be active, but feel they aren’t able to be or don’t know where to start. People worry about their basic needs before they can think about being active (e.g. access to housing, employment, food, education, technology, and good health).
- Small changes to how capable people feel can lead to big changes in physical activity levels - for everyone in Leeds to be more active, it is important they feel they can be.

Get Set Leeds continues hold conversations around how to get the city moving more. It has developed a website and campaign platform that is being used to promote consistent messaging around physical activity and for various projects which are outlined later in this report.

3.2 Covid-19 response

3.2.1 The significant impact of the Covid-19 pandemic on physical activity and in highlighting and widening existing inequalities in activity levels has also been reflected in the development of the Physical Activity Ambition.

The pandemic emphasised how important physical activity is for physical and mental wellbeing particularly in terms of:

- Deconditioning due to inactivity e.g. increasing the risk of falls, the impact on frailty and long term conditions.
- Inactivity in children and impact on academic achievement, behaviour and mental health.
- The importance of access to spaces and places to be active and the inequalities that exist.

3.2.2 A Covid-19 Rapid Literature Review was undertaken with Leeds Beckett University between January 2021 – April 2021 to understand the impact of Covid-19 on physical activity. This research demonstrated the potential role of physical activity in contributing to recovery; physical and mental reconditioning, and rebuilding from Covid-19. Further information is provided in the background documents in the form of a short report summarising the research findings.

The research also identified a likely link between sarcopenia (age related reduction in muscle mass) and a reduction in immunity which could be improved through physical activity. It supplemented the key findings from the Get Set Leeds conversation research and further emphasised the importance of physical activity in addressing growing health inequalities.

3.2.3 Various pieces of work have been developed in response to the pandemic and to help Leeds to recover from its impacts. A few examples are highlighted below:

- Through the Get Set Leeds – Local project the development and distribution of play boxes in Seacroft. This project is now being extended to people who have been shielding and/or have long term conditions via Sport England £50k funding.
- Production and distribution of the Healthy at Home Booklet and the development of the Healthy at Home Website for people with Long Term Conditions and those shielding. This promoted moving more in and around the home alongside Covid-19 messages and healthy living advice.
- Contributing, influencing and connecting colleagues across transport, highways and active travel to develop Active Travel Neighbourhoods. This includes submitting a bid for the Department for Transport's Walking, Cycling and Social Prescribing Fund. A decision as to whether or not the bid has been successful is imminent.

- Development of a series of Physical Activity Webinars for the wider workforce and Third Sector.

- Continued communication through blogs and social media posts through the Get Set Leeds website and Leeds City Council social media channels promoting the benefits to physical and mental health of being active as well as key Covid-19 messages.

3.3 PA Ambition Priorities and Next Steps

3.3.1 The Get Set Leeds conversations and Covid-19 review have shaped the shared ambition which is for Leeds to get "Get More People, More Physically Active, More Often" and drive a radical cultural shift to increase physical activity requiring commitment over the long term. This shared ambition and its work programmes will be co-produced at all levels.

3.3.2 In order to deliver the ambition to "Get More People, More Physically Active, More Often" action will be focused around four themes based upon the core ideas in the WHO Global Action Plan on Physical Activity 2018-2030 with reducing inequalities as a cross cutting aim:

ACTIVE SOCIETY – In Leeds we will create a social norm where it is the easiest choice to be physically active every day.

ACTIVE ENVIRONMENT - We will work with people to understand the external drivers affecting their physical activity levels

ACTIVE PEOPLE - We will work with identified target groups to create small changes to how capable they feel to be physically active every day and test new ways of working.

ACTIVE SYSTEMS - We will work in partnership to create a healthier place, a greener city and a stronger local economy.

3.3.3 In order to enable a more in-depth, co-produced and effective response to the post pandemic challenges it is proposed that Active Environments and Active People - Reconditioning are selected as an initial focus with inequalities being a central theme for both.

Proposed Priorities:

Active Environments	**Active People - Reconditioning**
Active Travel	Young People – physical literacy
Get Set Leeds Local – priority neighbourhoods	Learning Disabilities
Walking and cycling	Older People
Influencing strategy and policy	Long Term Conditions/Long Covid

3.3.4 These priorities have been selected because they are:

- Able to significantly impact on inequalities across the city.

- Present genuine opportunities for cross-sector / cross-cutting co-production with communities and key stakeholders.

- Emerging as key priorities from the Get Set Leeds Conversation and Covid-19 rapid review.

- Aligned to city priorities - Inclusive Growth, Health and Wellbeing and Climate Change.

- Areas where there is already momentum building and willingness to engage.

3.3.5 Co-production with communities is key to the successful development of work to address these priorities. A Leeds Physical Activity Ambition Co-Production Toolkit has been developed. This is a guidance document for everyone who is helping to make Leeds more active.

The Toolkit identifies different stages to help understand what co-production means in practice, to reflect on how we currently work and to consider any existing co-production examples currently in place. The key next step in our work is the co-design of both the Active Environments and Active People - Reconditioning priorities. This will involve identifying, bringing together and involving stakeholders, ensuring that anyone with a personal need or want is put at the heart of developing any change or solution. In order to begin the co-production of a shared vision, agreed priorities with partners and residents within each of the two priorities it will enable an understanding of the assets, strengths and the improvements needed in each part of the system.

3.4 Physical Activity Governance

3.4.1 Progress is also being made around creating the Physical Activity Governance structure which involves the establishment of a Physical Activity Partnership Board. The Partnership Board will provide strong systems leadership and accountability for the Physical Activity Ambition and action plans. The aims of the Partnership Board are to:

- Articulate the power of being physically active in delivering city outcomes, particularly in reducing inequalities.
- Lead and activate change.
- Focus on creating the right physical environment.
- Take an all age/population approach.
- Help to harness the power of people in communities to increase activity levels.
- Create connections and links to embed physical activity across the system.

Planning for recruitment to the Board is underway and is aimed at finding leaders who can provide strategic influence; those that will spearhead and champion different ways of working; and those who have influence within the two priority areas (Active People - Reconditioning and Active Environments). The Board will also

include experts both in terms of a resident's voice and academic / physical activity specialists.

The establishment of the Board is a key step in developing the Physical Activity Ambition, there is recognition of the importance of finding physical activity ambassadors, with the right skills, those who can build relationships, networks and trust, and drive the behaviours to develop leadership as a collective activity that anyone in the system can take up.

In addition to the proposed Board the following structures and delivery mechanisms are already in place:

- **Design Group** – operational, cross service including Active Leeds, Public Health, Health Partnerships, Leeds Beckett University and Comms & Marketing providing the support role to the Physical Activity Ambition

- **Physical Activity Ambition Steering Group** – partnership including Public Health, Active Leeds, Economic Development, Health Partnerships, Human Resources and cross-sector representation including citizens voice Healthwatch, Sport England, Leeds Beckett University and Yorkshire Sport, currently providing overall strategic direction for the Physical Activity Ambition until Partnership Board is in place

- **Sub-Groups -** for example Comms & Marketing, Co-production, Get Set Leeds – Local.

- **Physical Activity Champions** – Movers & Shakers, Leeds Girls Can, Walk and Ride Leaders. Further development is still needed recognising to develop and formalise the role of Champions.

3.5 **Role of System Leaders**

Support and action from system leaders is needed to mobilise the Physical Activity Ambition for the city. It is hoped that the following outcomes can be realised through effective system leadership around physical activity:

- All leaders start to tackle identified blockages and drive new ways of working.

- Leaders, organisations and communities start thinking about how they tackle inactivity in a different way.

- Improved strategic recognition of physical activity in a place with a focus on assets.

- Improved collaborative leadership and engagement of local leaders.

- The start of changing behaviours in the system itself and among communities

In their role as system leaders it would be helpful to understand how Health and Wellbeing Board members believe they can support the achievement of these outcomes.

4 Consultation, engagement and hearing citizen voice

4.1 The Physical Activity Ambition approach to reducing inactivity aims to connect work that is taking place at a city-wide level with a more in-depth engagement across the life course with priority neighbourhoods / communities and under-represented groups.

4.2 Coproduction/codesign is an embedded principle of working for the development of the Physical Activity Ambition. A detailed Co-Production Physical Activity Toolkit has been developed to support this approach to working.

4.3 Get Set Leeds engaged over 4,000 people through a citywide survey and focus groups. We are continuing to talk to those we have started conversations within priority neighbourhoods and with priority groups through focus groups and Leeds Girls Can.

5 Equality and diversity / cohesion and integration

5.1 There is robust evidence to demonstrate that certain groups of the population who live in the most deprived areas of the city are more likely to suffer increased ill health and diseases. The Physical Activity Ambition will seek to reduce inequalities and try to avoid approaches and interventions that may widen them.

5.2 A key part of the approach to the Physical Activity Ambition is that resources will be more focused and interventions more tailored into those areas and communities with the worse health outcomes. There is a commitment to Asset Based Community Development and coproduction principles and to work closely with residents, local leaders and partners in embedding physical activity at a locality level.

6 Resources and value for money

6.1 The social return on investment from increasing the numbers of people being more physically active is significant for the city including social, economic, physical and mental health benefits.

6.2 A successful submission to Sport England has seen £475,000 in additional funding to help focus this learning and understanding of affecting long term behaviour change around being more active in some of the priority neighbourhoods, with an aim of building those wider health and wellbeing benefits and reducing health inequalities.

6.3 The Physical Activity Ambition work is funded through time limited grants and this project is working to achieve long term behavioural change, consideration needs to be given to the sustainability of the resources to fully realise the benefits.

6.4 Public Health, Active Leeds, Health Partnerships, Planning and Transport colleagues all collaborate and lead the project along with contributions from

partners in the Place Based Partnership, Sport Leeds Board, Leeds Becket University, and the Third Sector.

7 Legal Implications, access to information and call In

There are no legal implications arising from this report.

8 Risk management

8.1 There are no major specific risk issues identified. In future it is envisaged that Physical Activity Ambition work will be governed through the new Physical Activity Ambition Board governance structures, currently in development. In the meantime, there is a Physical Activity Ambition Steering Group in place to take overall responsibility for this work.

9 Conclusions

9.1 Now more than ever embedding physical activity into everyday life provides a unique opportunity to contribute to the three city strategic pillars of Inclusive Growth, Health and Wellbeing and Climate Change. Realising our ambition to increase levels of physical activity has the potential to contribute to a healthier place, a greener city and a stronger local economy.

9.2 This report has described progress in developing the Physical Activity Ambition and the response to the challenges presented by Covid-19 particularly around inequalities. Two priorities around Active Environments and Active People – Reconditioning have been proposed as a next stage focus. In order to complete the establishment of effective governance arrangements a Physical Activity Partnership Board is being proposed. A series of system leadership outcomes have also been set out and views are requested on the role of the Health and Wellbeing Board in realising them.

10 Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress presented and support the proposed next stage priorities of Active Environments and Active People - Reconditioning.
- Support the establishment of the Physical Activity Partnership Board as part of governance arrangements.
- Consider their role in realising a number of system leadership outcomes to support the achievement of the Physical Activity Ambition.

11 Background documents

11.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?

Collaborative approaches provide a structure and focus to be more effective and will help reduce health inequalities. Physical inactivity negatively impacts both physical and mental health and it is in the top 10 greatest causes of ill health nationally.

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

The PA Ambition has a preventive approach and will contribute to several of the key outcomes across the life course and will deliver future health benefits. This will decrease the demand on health and adult social care services.

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

The Sport England, Sport Industry Research Centre (2020) Social, Health and economic value of community sport and physical activity in England estimates the value of physical activity and sport as follows:

Social return on investment of PA and sport - Community physical activity generates £85.5 billion social and economic benefits annually - £1 spent generates £3.91 worth of social impact - £9.5 billion in physical and mental health benefits: - £5.2bn healthcare, £1.7bn social care savings - >£3.6bn savings by prevention of 900k diabetes cases - Further £3.5bn through avoided dementia cases & related care - £450m preventing 30m GP visits

Future challenges or opportunities
Develop strong system leadership across all partners that develops and supports the PA Ambition

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	x
An Age Friendly City where people age well	x
Strong, engaged and well-connected communities	x
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	x
Maximise the benefits of information and technology	
A stronger focus on prevention	x
Support self-care, with more people managing their own conditions	
Promote mental and physical health equally	x
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	

Appendix A

COVID-19 Rapid Reviews

Short Report

April 2021

COVID-19

As a highly transmissible disease, coronavirus (COVID-19) required physical distancing protocols and/or self-isolation. In response, worldwide, governments mandated movement restrictions using quarantine and lockdowns. These restrictions have had severe impacts worldwide on the health system and daily life.

Approach

In order to successfully plan future strategies, it was seen as vital to understand the impact COVID-19 has had on health and lifestyles. Leeds Beckett University was commissioned to undertake a rapid review of the COVID-19 evidence base. From January to April 2021, fortnightly reviews were undertaken. At the end of every two-week period, Leeds Beckett University would present back the findings, implications, and recommendations for the topic areas chosen. Following these presentations, discussions were held to inform on the next two-week period and come to consensus on the most important topics to cover next.

The topics covered were:

- Change in Physical Activity
- Physical Activity and Prevention of COVID-19
- Health Conditions and Shielders
- BAME, Diabetes and Physical Activity
- Mental Health and Physical Activity
- Deprivation and Social Determinants of Health
- Deconditioning and Disabled Individuals
- Recovering from Disasters and Resilience
- Long-Covid
- Access to Health Care
- Children and Young People
- LGBT
- Workplaces

Key Findings

1. **Physical activity has decreased, sedentary time has increased, but physical activity has preventive benefits to COVID-19**

Findings suggest a decrease in physical activity, with this decrease seen across all domains of activity (moderate, vigorous, MVPA, and walking). Along with the decrease in physical activity, there was also a significant rise in sedentary behaviour. Even short-term physical inactivity (1-4 weeks) has been associated with decreased health, but with the prolonged time spent at home, it is likely more health problems will ensue from the lack of activity. While physical activity levels pre-pandemic were low, it is now an even bigger problem as activity has further decreased. Based on previous evidence around other similar infections diseases, engaging in physical activity promotes positive health benefits, including improved immune system response and lower risk of severe future complications. Therefore, physical activity should be promoted to prevent future coronavirus contraction.

2. **Long-covid impacts 10% of people, many people suffering long-term problems**

Long-covid, or prolonged illness after COVID-19, can have many negative effects including: inability to engage, lack of aspiration, attention, planning, poor emotional control, higher anxiety levels and lost routines. It is unknown exactly how long individuals with long-covid will be impacted, so it will require carefully planned interventions which focus on the recovery of these individuals are needed in conjunction with medical professionals for the more serious cases. It is also a long-term problem, as people can suffer from long-covid for over 12+ weeks.

3. **Mental health problems have increased**

Physical activity can potentially protect against depression, anxiety and poor mental health. However, the decline in physical activity levels during COVID-19 has been associated with increased stress, anxiety, and depression. Interestingly, those who participated in more physical activity during the pandemic was associated with more positive mental health. It is therefore increasingly important to promote physical activity and building other factors such as confidence in one's own ability and drawing on the social support of reduced social networks, which can protect against common mental health problems.

4. **The pandemic has led to the widening of the inequalities gap**

While the pandemic has affected regions differently over the course of the pandemic, the close association between underlying health, deprivation, occupation and ethnicity and COVID-19 have made living in more deprived areas in some regions particularly hazardous. The declines in income since March 2020 have been unequal, and lower-income groups have lost a greater proportion of their income from earnings than better-off groups. During the COVID-19 pandemic, housing has also become an even greater determinant of health and wellbeing. Additionally, BAME groups are more greatly impacted; in relation to their white counterparts, individuals who are black ethnicity are 4x more likely to die from COVID-19. This highlights that inequalities in health behaviours should be a priority action area and interventions should be developed to improve healthy behaviours and reduce inequalities.

5. **In this for the 'long haul', long road to recovery – community engagement is essential for re-building**

Findings suggest that disaster exposure, such as a pandemic, continues to impact quality of life for many years, though the nature and duration of these impacts vary and may be influenced by factors such as age, gender, education, and vocation. Individuals reactions vary, but there is a common pattern among individuals exposed directly or vicariously to life-threatening events. Overall people experience a range of emotional responses at different phases of a disaster. It can take between 6-36 months to recover from a disaster; it is important to note that there is no quick fix and will take a while to get back to pre-disaster levels. It is essential to engage the community at a local level for successful recovery. Communities will need to be empowered to identify those groups who are missing out or struggling themselves.

Implications

Leeds pre-COVID findings in have been compared to the findings from the rapid review. Key implications are provided in the following table.

Previous Get Set Leeds Findings	COVID-19 Implications
Inactive people prioritised meeting their basic needs before being more active	COVID-19 widened the inequalities gap; it is likely more people will be worse off than before the pandemic. Therefore, more people will need to focus on their basic needs and physical activity won't be a priority. This highlights the need for social and environmental factors to be more supportive
Inactive people want to be active, but feel they aren't able to be	This is just as, if not, more important now in a COVID and post-COVID-19 world. New barriers or competing interests/concerns may now

	exist. This highlights the continual need for social and environmental factors to be supportive
Changes across the system to improve capability had the greatest impact on physical activity	With even less access and the additional fear around COVID-19, it has probably led to greater feelings of reduced capability. It remains important to re-activate capability, so individuals are enabled to be active
LGBT groups were identified as a key target group	Results indicated that LGBT groups felt they needed more dedicated environments that are socially supportive and more inclusive. The research on COVID-19 suggests that LBGT should remain a key target group moving forward and that LGBT individuals may have been disproportionally impacted
Employees felt their workplaces should focus on supporting them to be physically active	Physical activity has decreased and new challenges of working from home require a new approach from employers
Employers need to provide flexible working practices, create a culture where active working is the norm and empower employees to move more	This is still important remains important for employees – COVID has demonstrated that flexible working can work successfully, and employees still want this option post-pandemic

Recommendations

Four key recommendations have arisen from the research. These are:

1. **Reactivate feelings of capability and motivation, and provide opportunities to re-engage in activity** – it is now more important than ever to ensure people feel able and encouraged to be active, while providing safe opportunities to do so.
2. **Physical activity may not be a priority for most people; consider how to approach and encourage this behaviour** - basic needs such as income or housing will be more important, and we need to consider how to approach and encourage physical activity in a compassionate way, while acknowledging and sharing struggles with others.
3. **Address new barriers or competing interests/concerns** – COVID-19 has brought in new barriers to being physically active. It is likely many individuals will still be cautious and worried about engaging in activity in a post-COVID environment. These barriers will need to be considered and strategies will need to be implemented to reduce them.
4. **Accent supportive social and environmental factors** - With restrictions easing, there are now opportunities to see friends and family again, need to take advantage of this and provide the chance to make small changes to their daily lives. It will be important to activate the idea of 'N5' by offering programmes that are near, now, no-cost or low cost, new, and next-wise.

Conclusion

The findings from this research can be used to as an indicator as to what's changed as a result of COVID-19 and provides recommendations for how to continue to support Leeds in its journey to becoming more active. COVID-19 has greatly impacted individuals lives, approaches to public health, and the wider system. By applying it directly to the city of Leeds context, it enables a clear picture of what's needed to continue to support people living in Leeds in becoming more active.

Recommendations outline wider system changes that account for COVID-19 and the new challenges that have arisen. The results from this research will be used to adapt and rethink future action plans, while continuing to co-produce a physical activity ambition plan.

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Mandy Sawyer
Tel: 0113 5350703

Report of: Head of Housing and Homelessness

Report to: Leeds Health and Wellbeing Board

Date: 6th December 2022

Subject: Review of the Leeds Housing Strategy

Strapline: This report informs the Health and Wellbeing Board about the review of the city's Housing Strategy and seeks comment from the Board.

Comms & Engagement: A review is underway to produce a new 5 year Leeds Housing Strategy. The strategy review will be underpinned by the Council's 3 strategic pillars including the Health and Wellbeing Strategy. Consultation and engagement on the housing strategy priorities will take place during November and December, with a view to finalising the updated strategy by April 2022.

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The current Housing Strategy has been in place since 2016 and sets out the long-term plans for providing housing that is affordable, of good quality, that meets the needs of the citizens, enhances the quality of the environment, supports health and wellbeing and fosters cohesive communities. The strategy has a key role in supporting the Council's three strategic pillars including the Health and Wellbeing Strategy.

A review of the Housing Strategy is underway. The six strategy themes remain very relevant and so it is proposed that these are retained and tweaked slightly to ensure closely aligned to wider strategic priorities. The proposed six themes are increasing affordable housing supply, improving housing quality, reducing homelessness and rough sleeping, creating sustainable communities, improving health through housing and age friendly housing.

The Housing Strategy has a key role in identifying how we will improve health through housing, with important connections to the Health and Wellbeing Strategy. A number of proposed health and housing priorities for the Housing Strategy are outlined in paragraphs 3.6 and 3.7 of this paper.

The consultation and engagement phases of the Housing Strategy review will take place during November and December. The strategy will be drafted during January with a view to seeking formal approval from the Council's Executive Board in April 2022.

A further Housing and Health agenda item is planned for Health and Wellbeing Board meeting in February 2022, to discuss strategic leadership of the health and housing priorities via the two strategies.

Recommendations

The Health and Wellbeing Board is asked to:

- Note and comment on the proposed approach to reviewing the Housing Strategy.
- Comment on how the Housing Strategy priorities, including the health and housing theme can support the delivery of the Health and Wellbeing Strategy.
- Note the health and housing agenda item planned for the Health and Wellbeing Board meeting in February 2022.

1 Purpose of this report

1.1 This report informs the Board of the current review of the Leeds Housing Strategy, and seeks input from the Board on how the strategy can support the Health and Wellbeing Strategy by improving health through housing.

2 Background information

2.1 The current Housing Strategy has been in place since 2016 and sets out the long-term plans for providing housing that is affordable, of good quality, that meets the needs of the city's citizens, enhances the quality of the environment, supports health and wellbeing and fosters cohesive communities.

2.2 The Housing Strategy has a critical role to play in helping the Council to achieve its overarching goal of meeting its 'Three Key Pillars' outlined in the Best Council Plan of delivering Inclusive Growth, improving the Health and Wellbeing of all our citizens, and tackling Climate Change. Attached in appendix one is a summary of how the Housing Strategy supports each of the three strategic pillars.

2.3 The condition of the city's housing stock directly affects each of these three pillars. A good supply of affordable housing, that has high energy efficiency helps to support inclusive growth. Good housing fosters good health and wellbeing in many ways, affecting both physical and mental health. The energy efficiency of the city's housing stock, in both the social and private sectors, will play a huge role in determining how the city progresses in reaching its zero carbon goals.

2.4 There is increasing national evidence to support the strong link between health and housing. In 2015 BRE estimated that poor quality housing costs the NHS £1.4bn each year.

2.5 Recent Joint Strategic Assessments of Leeds have highlighted an increase in the number of Lower Super Output Areas in Leeds which fall within the bottom 10% nationally. The most deprived areas are concentrated in inner city communities where there are high concentrations of social and private rented sector housing. The Housing Strategy has a key role in setting out how the housing sector can support wider strategies to reduce poverty and deprivation in neighbourhoods through providing good quality affordable homes which are energy efficient to help reduce fuel poverty and maximise health.

2.6 Housing quality in the private rented sector remains a Housing Strategy priority. There are a number of proactive approaches to improving housing quality in the private rented sector. The Private Sector Team assess housing standards via the 29 Housing Health and Safety Rating System, supporting landlords to address risks and targeting those which fail in their legal duties. To support landlords the Council supports the Leeds Rental Standard which is a self regulation scheme for landlords.

2.7 The Council also proactively targets poor quality homes via licensing, both mandatory HMO licensing and selective licensing, the Leeds Neighbourhood Approach (LNA) and targeting overdeveloped homes where people have inadequate living space. Using the powers available to us we are able to take

appropriate legal action to address standards which affect the well-being of occupants and ensure that their homes are safe and free from category 1 hazards. By crossing the threshold it also provides an opportunity to work with partners to address non housing needs such employment, training financial inclusion, access to health care and support needs.

3 Main issues

3.8 The current strategy is comprised of six key themes which represent the priorities for the city. It is proposed to largely retain these themes, but with some tweaks from the previous strategy. The proposed updated themes are outlined in appendix two, made up of the following:

- **Affordable Housing Growth** – to maximise the number of affordable homes available to buy and rent, through measures such as help to buy schemes, promoting starter homes and to increase the quality of new housing.

- **Improving Housing Quality** – to improve the quality and energy efficiency of homes, particularly in the private sector, and reducing the number of empty homes.

- **Reducing Homelessness and Rough Sleeping** – formerly called 'Promoting independent living', this theme has been renamed to reflect the fact that its fundamental aim is to reduce homelessness in the city. Elements of the old theme that are not directly linked to homelessness will be included within the health and housing or Age Friendly theme.

- **Creating sustainable communities** – to create confident communities through effective management the neighbourhood environment and tackling anti-social behaviour, domestic abuse, and crime. Links to the Inclusive Growth Strategy will be identified within this theme.

- **Improving health through housing** – promoting healthy lifestyles, reducing health inequalities, and supporting people to meet health needs through housing options. Links to the Health and Wellbeing Strategy will be identified within this theme.

- **Age Friendly Housing –** formerly 'Meeting housing needs of older residents', this theme seeks to ensure that the right housing options are available which allow older people to remain active and independent in their homes and communities.

3.9 The main areas identified where the Housing Strategy can support the Health and Wellbeing Strategy are outlined in appendix one. These are as follows:

- Supporting good mental and physical health through improved housing quality, particularly in the private rented sector and improved affordability
- Providing age friendly housing which supports independence, self-care, and social inclusion

- Improving accessibility through supporting a ‘prevention’ approach, e.g., homelessness, rough sleeping, mental health, care leavers
- Ensuring that the housing environment enables people to be healthy, social, and active
- Promoting strong, well-connected communities and pride in sustainable local neighbourhoods
- Maximising the benefits from technology to improve health and wellbeing linked to housing
- Ensuring that housing needs are met through integrated models of care
- Supporting the system to respond to the impacts of COVID on health and wellbeing

3.10 Whilst many of the health and housing connections into the Housing Strategy are embedded within a number of strategy themes it is proposed that the ‘Improving Health through housing’ theme is focused on how the health and housing sectors can work together as part of the system to ensure improved health through housing. The main priorities proposed within this theme are:

- Supporting independence through housing – maximising collaboration on adaptations, hospital prevention / discharge
- Strengthening collaboration between sectors – improved awareness and partnership working across the housing and health sectors – basic assessment skills, knowledge of pathways, knowing who to contact
- Supporting system efficiencies - the Housing sector’s role in providing proactive housing solutions for complex and high-cost health / social care cases – targeted case management work with Social Care and Health agencies to meet housing needs of individual and families with very complex needs, high system costs.
- Digital solutions to monitor housing conditions and health impacts, e.g., Gov Tech Project which is using environmental sensors to monitor resident health and wellbeing.
- Information and data sharing – e.g., housing information on Local Care Record
- Strengthened role of housing sector on Local Care Partnerships
- Improved referral pathways between health and housing e.g., homelessness, mental health.
- Adopt System Thinking approaches across Housing sector – Better Conversations, Making Every Contact Count, Trauma Based approaches

3.11 The strategy will be for the next five years, to ensure that there continues to be a framework that guides the city in meeting the housing needs of all citizens. The planned approach will include the following:

3.12 ***October–December 2021 - Consultation and engagement phase:***

- Significant engagement took place with partners and Council teams on each theme of the 2016-21 Housing Strategy during 2018-19 via a series of Leeds Strategic Housing Partnership workshops. These workshops helped to identify a series of collaborative priorities and organisational commitments. In most cases these priorities remain very relevant, and actions are underway to progress these commitments. The focus of this consultation and engagement

phase will therefore be on reviewing whether there is any change to these priorities over the last couple of years. Consultation and engagement will take place via the following:

- An online workshop was held on 16th November, attended by a wide range of stakeholders, both internal and external to the Council. Breakout sessions were held which gave stakeholders the opportunity to engage directly on particular themes, including Health and Wellbeing.

- Discussions are taking place with Council's Policy Network members and Directorate Leadership Teams to ensure that the Housing Strategy is closely aligned to other Council strategies and policy.

- As part of the Equality Impact Assessment, the city's five Equality Hubs have been approached to ensure that consideration is given to the equality impacts of the strategy.

- A website has been launched, via the Council's 'Your Voice Leeds' portal which offers the opportunity for citizens to provide input into the Housing Strategy. It will be publicised via the Council's social media channels and via email directly to Council tenants.

3.13 ***January 2022 – Collation and Drafting of the Housing Strategy***

- The outcomes of the consultation phase will be brought together, and a draft strategy produced

3.14 ***February – April 2022 – Final Consultation and Scrutiny***

- A workshop will be held with the Environment, Housing and Communities Scrutiny Board in February to provide an update on the consultation and engagement phase and provide an opportunity for the Board to scrutinise the draft strategy priorities. A particular focus will be placed on the improving housing quality, reducing homelessness and rough sleeping and age friendly housing themes at the workshop.

- The draft strategy will be shared with the Leeds Strategic Housing Board for final comment.

- The draft strategy will be shared with Executive Board in April 2022 for final consideration and decision making.

3.15 ***May 22 onwards – Roll Out and Promotion of the Housing Strategy***

- Once approved the updated Housing Strategy will be promoted across Council teams and with partners. The strategy will be published on the Leeds City Council website and promoted via social media.

3.16 Health and housing is already planned as a major agenda item of the February 2022 Health and Wellbeing Board meeting. It is proposed that the meeting discusses how strategic leadership is provided to the health and housing priorities in both strategies.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 The consultation and engagement process is outlined above.

4.2 Equality and diversity / cohesion and integration

4.2.1 A full Equality Impact Assessment is planned as part of the Housing Strategy review.

4.3 Resources and value for money

4.3.1 The Housing Strategy will help outline the city's housing priorities over the next five years, and as such will help the city to focus its resources on the city's biggest priorities and make sure efforts across all sectors are focused on the Key Pillars of delivering Inclusive Growth, improving the Health and Wellbeing of all our citizens, and tackling Climate Change.

4.4 Legal Implications, access to information and call In

4.4.1 The Council has a range of statutory duties relating to housing, homelessness, and reviewing housing conditions. This strategy will assist the Council in meeting those duties.

4.5 Risk management

4.5.1 The main risk is that the updated Strategy fails to meet the housing needs of the city in the coming years in the areas it is considering. The Strategy's themes have a major impact across all the city's communities and all age groups. If the Strategy fails to reflect the needs of the city, then there is the risk that the development of housing in the city doesn't properly reflect the city's needs.

4.5.2 This risk is being managed by carrying out an extensive consultation and engagement exercise, that is aiming to get the input of the widest number of stakeholders, communities, and citizens as possible, to tailor a strategy that is robust and has the buy in from stakeholders across the city. The Leeds Strategic Housing Partnership will help to ensure continued engagement with the wider sector during the period of the updated Housing Strategy.

5 Conclusions

5.1 In reviewing the Housing Strategy there is an opportunity to ensure that the Health and Wellbeing Strategy priorities are embedded within the Housing Strategy, to ensure that we maximise the opportunity to improve health through housing in the city.

5.2 In attending Health and Wellbeing Board as part of the Housing Strategy's engagement phase ensures that there is the opportunity and time available to ensure that priorities are aligned.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note and comment on the proposed approach to reviewing the Housing Strategy.
- Comment on how the Housing Strategy, including the health and housing theme can support the delivery of the Health and Wellbeing Strategy.
- Note the health and housing agenda item planned for the Health and Wellbeing Board meeting in February 2022.

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?

The condition of the city's housing stock, across the social housing, rented and owner-occupied sectors, has a huge role to play in promoting good physical and mental health. The Strategy will help to shape the city's approach to housing over the next five years that will help to ensure the health and wellbeing of the city's residents.

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

Good quality, suitable housing helps to reduce the pressure on hard-pressed services. The Strategy considers issues such as how to ensure suitable housing for older people, that contributes to a high-quality care system.

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

By reducing pressure on the NHS by, for example, helping to reduce falls in the home, or ensuring there is suitable accommodation for people when they leave hospital.

Future challenges or opportunities

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	

The best care, in the right place, at the right time	X

This page is intentionally left blank

LEEDS CITY COUNCIL'S THREE PILLARS AND THE LEEDS HOUSING STRATEGY

The Council has identified three 'Key Pillars' that provide a strategic framework for progress in the city, aligned to the Best Council Plan. The Housing Strategy has a fundamental role in supporting each of these Pillars

1

INCLUSIVE GROWTH STRATEGY

The housing sector has a key role in supporting inclusive growth:

2

HEALTH & WELLBEING STRATEGY

The housing sector has a key role in supporting health and wellbeing:

3

THE CLIMATE EMERGENCY

The housing sector has a key role in supporting the Council's climate emergency ambitions:

HOW THE HOUSING STRATEGY SUPPORTS THESE PILLARS

- Building more affordable homes
- Targeting investment to tackle poverty, e.g. COVID impacts, priority neighbourhoods
- Supporting strategic placemaking principles, ensuring that housing contributes to creation of local neighbourhoods
- Making assets work to support communities and growth through Asset Based Community Development
- Maximising digital inclusion
- Securing inclusive growth principles through employment and procurement in the housing sector
- Supporting economic recovery of city and local centres through housing

- Supporting good mental and physical health through improved housing quality and affordability
- Providing age friendly housing which supports independence, self care and social inclusion
- Improving accessibility through supporting a 'prevention' approach, e.g. homelessness, rough sleeping, mental health, care leavers
- Ensuring that the housing environment enables people to be healthy, social and active
- Promoting strong, well-connected communities and pride in sustainable local neighbourhoods
- Maximising the benefits from technology to improve health and wellbeing linked to housing
- Ensuring that housing needs are met through integrated models of care
- Supporting the system to respond to the impacts of COVID on health and wellbeing

- Building 'greener' new housing developments with stricter energy efficiency standards
- Supporting sustainable transport options as part of new housing developments
- Supporting strategic placemaking principles
- Decarbonation of existing housing stock and improving energy efficiency
- Reducing fuel poverty through improved heating and insulation
- Supporting wider climate and flood resilience through green infrastructure in areas of housing
- Supporting climate emergency ambitions through organisational service delivery and procurements, e.g. grey mileage, office estate
- Supporting citizen engagement on climate emergency ambitions

This page is intentionally left blank

Appendix 2

OUR HOUSING VISION

Effectively meeting affordable and social housing need, promoting independence and creating sustainable communities to make Leeds the best place to live.

All Leeds residents will be living in:

- good quality affordable homes
- homes with appropriate levels of support
- safe and harmonious communities

Having considered the current housing market and population changes, housing policy and external factors we have established 6 key themes which are a priority within this 5 year Housing Strategy.

1 AFFORDABLE HOUSING GROWTH

Maximising the amount of affordable homes available to rent and buy

2 IMPROVING HOUSING QUALITY

Improving the quality and energy efficiency of homes, particularly in the private sector and reducing the number of empty homes

3 REDUCE ROUGH SLEEPING AND HOMELESSNESS

Minimising homelessness through greater focus on prevention, and supporting vulnerable residents to live independently

4 CREATING SUSTAINABLE COMMUNITIES

Creating confident communities through effective management of the neighbourhood environment and tackling anti-social behaviour, domestic abuse and crime

5 IMPROVING HEALTH THROUGH HOUSING

Promoting healthy lifestyles, reducing health inequalities and poverty, and supporting people to meet health needs through housing options

6 AGE FRIENDLY HOUSING

Ensuring that the right housing options are available which allow older people to remain active and independent in their homes and communities

This page is intentionally left blank

Leeds Health and Wellbeing Board

Report author: Lesley Newlove

Report of: Helen Lewis, Director of Pathway Integration, NHS Leeds CCG and Caroline Baria, Deputy Director Integrated Commissioning, Adults and Health, Leeds City Council

Report to: Leeds Health and Wellbeing Board

Date: 6th December 2021

Subject: Leeds Better Care Fund Plan 2021-22

Strapline: To review and retrospectively sign off the Leeds BCF Plan for 2021-22

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	X No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	X No
Is the decision eligible for call-In?	☐ Yes	X No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	X No

Summary of main issues

The current Leeds Better Care Fund (BCF) Plan 2021/22 ended in March 2021 and NHS Leeds CCG and the Local Authority are required to submit a new plan to the National Better Care Team for assurance. However, the NHS England BCF Policy Framework and Planning Requirements 2021/22 were only published on 30th September 2021 and our plan had to be submitted by 16 November 2021.

The Health & Wellbeing Board is responsible for signing off the Leeds BCF Plan, but the submission timeframe did not align with the meeting dates of the Health and Wellbeing Board and so the plan was signed off by the Chair of the Health and Wellbeing Board prior to submission on the condition that it was retrospectively signed off by the Health and Wellbeing Board at their next meeting.

Recommendations

The Health and Wellbeing Board is asked to:
Retrospectively sign off the Leeds BCF Plan 2021/22 which has been submitted to the National Better Care Team for assurance in accordance with the deadline of 16th November 2021

1.0 Purpose of this report

1.1 The purpose of this report is to obtain retrospective sign off from the Leeds Health & Wellbeing Board for the Leeds BCF Plan 2021/22.

2 Background information

2.1 The BCF was established in 2013 and is a national programme spanning both the NHS and local government. It represents a unique collaboration between NHS England, the MHCLG, DHSC and the Local Government Association. The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the Long-Term Plan.

2.2 The BCF encourages integration by requiring CCGs and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

3 Main issues

3.1 The current Leeds BCF Plan ended in March 2021 and NHS Leeds CCG and the Local Authority are required to submit a new plan to the National Better Care Team for assurance following publication of the NHS England BCF Policy Framework and Planning Requirements 2021/22 on 30th September 2021.

3.2 Extensive work with health and care partners in Leeds has been undertaken over the past 12 months to simplify the Leeds Better Care Fund and ensure it broadly reflects the health and wellbeing priorities of Leeds. These key areas are:-

- Mental Health Services
- Community and Third Sector Services
- Home First and Care at Home Services
- Information Technology and support to the Leeds Care Record

3.3 The deadline for submitting a new Narrative Plan and completed Planning Template for assurance by the National Better Care Team was 16th November 2021. This timeframe did not align with the meeting dates of the Health and Wellbeing Board and so the plan was signed off by the Chair of the Health and Wellbeing Board prior to submission on the condition that it was retrospectively signed off by the Health and Wellbeing Board at their next meeting.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 The Leeds BCF Plan 2021/22 broadly reflects the health and wellbeing priorities of Leeds and business as usual work of a number of key system working groups. Partners are well involved in these groups which are multi-agency and multi-partner including 3rd Sector providers and groups such as the Leeds Oak Alliance.

4.2 Equality and diversity / cohesion and integration

4.2.1 The Integrated Commissioning Executive (ICE) serves as the BCF Partnership Board. The main funds have been allocated to work programmes which fall under the oversight of our Mental Health governance arrangements (currently being developed alongside our place-based partnership arrangements, our Frailty Programme Board, and our System Flow Programme Board. The link between these groups and ICE is through lead officers from the NHS and Adults and Health, Leeds City Council. The Director of Pathway Integration, NHS Leeds CCG, and the Deputy Director of Integrated Commissioning (a joint appointment between LCC and the NHS) are the lead and supporting commissioners for all the schemes in the Fund. All the work areas have the input of colleagues across the system, including VCSE and user voice, although some of the user engagement requires further development and has been constrained by Covid and service pressures. We do not see the BCF as separate, but as a key enabler to our work programmes in the designated areas.'

4.3 The agreed approach in Leeds to date has been to use the BCF in such a way as to derive maximum benefit to meet the financial challenge facing the whole health and social care system. Continuing to invest in existing services not only provides stability for those services and service users but also delivers value for money and makes the best use of the Leeds £ aswell as addressing the aims of the BCF sources and value for money

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal implications, access to information or call-in implications from this report.

4.5 Risk management

4.5.1 Any risks to services are monitored by the governance groups monitoring service delivery.

5 Conclusions

5.1 The Leeds Better Care Fund 2021/22 has been considerably simplified and aligned better to existing system governance structures which has representation from key partners from all sectors. The pooled resources in the BCF enables Leeds to focus on reducing health inequalities, improve system flow and support people to remain living independently at home and

6 Recommendations

The Health and Wellbeing Board is asked to:

- Retrospectively sign off the Leeds BCF Plan 2021/22 which has been submitted to the National Better Care Team for assurance in accordance with the deadline of 16th November 2021.

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
The BCF is a national programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

How does this help create a high-quality health and care system?
The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.

How does this help to have a financially sustainable health and care system?
The pooled resources are utilised to maximum effect and are targeted at reducing health inequalities and to support people to remain living independently in their home.

Future challenges or opportunities
The impact of Covid on service delivery and backlogs remain a challenge however the pandemic has also produced opportunities for further integration.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	

The best care, in the right place, at the right time	X

This page is intentionally left blank

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Leeds

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

In 21/22 we have simplified the groups of schemes within the BCF so that the BCF Plan for Leeds is overseeing work that is the business-as-usual work of a number of key system working groups. Partners are therefore well involved in this work via the work of those groups, which are all multi-agency and multi-partner. So, for example, the System Flow Programme Board has representation from all key NHS Providers and Local Authority commissioner and provider representatives, and the working groups feeding into this include 3rd sector partners including the Oak Alliance. We work closely with housing partners, particularly where patients need housing support on discharge, and have strong local schemes around support with adaptations on discharge, Telecare and other support arrangements. In particular, our Housing Options team are closely connected to our work. The Mental Health schemes within the BCF are overseen by the emergent Mental Health governance structures, which again have significant representation from across the City. In particular, during 21/22 there has been significant engagement around the re-procurement of 3rd sector Mental Health provision, where colleagues have been consulted on the nature and shape of this provision and how to streamline the commissioning arrangements for this. Housing partners are key to all our mental health and LD work and we work closely with them around accommodation and accommodation support. There are weekly system operational forums which cover all system partners which again provides an opportunity to ensure that all partners can highlight areas of concern which are then addressed through some of the BCF schemes. Healthwatch and user voice are engaged with these work plans at a number of levels and their findings are embedded into the service changes considered by the BCF Delivery groups.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The key changes in 21/22 are that we have met as a Health and Care System to consolidate the various schemes within the BCF so that they are more clearly aligned with existing System Governance structures. The schemes are broadly overseen by the Mental Health governance arrangements, the Frailty Programme Board, and the newly formed System Flow Programme Board. This means that the BCF funds are being deployed within a clear city-wide governance arrangement which has representation from key partners from all sectors

The key changes in 21/22 relate to the major system pressures linked to the ongoing impact of the Covid-19 pandemic and its impact on people's lives, health and the workforce required to deliver care. Hospital discharge and system flow remain a key priority, both for acute hospital patients but also for those patients in specialist mental health settings. We have had a considerable focus on improving the efficiencies of the Intermediate Tier beds in the City, which have an even greater part to play as the thresholds for 'no reason to reside' have tightened in response to Covid. We have also invested in the City reablement and equipment services, to maximise options for care at home wherever possible within workforce and supply constraints. Priorities and spend have to some extent been skewed by the availability of Hospital Discharge Fund which has created additionality into the system. Key schemes in 21/22 include: additional social work capacity to reduce downstream delays; therapy supported discharge, maximising productivity in reablement, and enhancing care at home such as night sitters and additional home carers to support the increased numbers of people wishing to die at home.

We have included the Primary Care Frailty scheme within the BCF, believing its core purpose which is to optimise the care of frail people has a direct link into the ambitions of the BCF to reduce hospital admissions and lengths of stay. Alongside the community geriatricians and ensuring medical support to our intermediate care beds is robust, we are aiming to ensure that people can stay out of hospital for as long as possible, even if they have increased needs.

Our Mental Health services have had particular challenges this year, but we are clear that the 3rd sector partners whose contracts are included within our BCF envelope, have had an invaluable role in supporting the health and wellbeing of many people throughout the pandemic. We have used the complementary skills of our 3rd sector providers to ensure there is a range of options available to people with acute and enduring mental health needs, that is not only provided by registered staff and statutory organisations but can be more tailored to a non-clinical and more community responsive offer if appropriate. Key areas of focus include alternatives to statutory services for crisis, enhanced support for people in community mental health settings, and support to access employment. .

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Integrated Commissioning Executive (ICE) serves as the BCF Partnership Board. The main funds have been allocated to work programmes which fall under the oversight of our Mental Health governance arrangements (currently being developed alongside our place-based partnership arrangements, our Frailty Programme Board, and our System Flow Programme Board. The link between these groups and ICE is through lead officers from the NHS and Adults and Health, Leeds City Council. The Director of Pathway Integration, NHS Leeds CCG, and the Deputy Director of Integrated Commissioning (a joint appointment between LCC and the NHS) are the lead and supporting commissioners for all the schemes in the Fund. All the work areas have the input of colleagues across the system, including VCSE and user voice, although some of the user engagement requires further development and has been constrained by Covid and service pressures. We do not see the BCF as separate, but as a key enabler to our work programmes in the designated areas.'

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

In accordance with our Integrated Commissioning Strategy, and through our commissioning arrangements, we continue to invest in community services which are based on promoting independence principles. Our strengths-based approach is embedded in our conversations with people who use health, care, and support services, with a focus on maximising the support provided by their families and unpaid carers, or through their local communities.

Joint priorities for 21/22:

- Intermediate Tier – a) Ensure sufficient capacity of out of hospital community bed-based Discharge to Assess provision Pathways 2 and 3; b) Market engagement and development of new models of Intermediate Tier provision); c) Maximise use of equipment/AT through Leeds Community Equipment Service

- Older people's care homes –increase dementia care provision including for complex needs; ensure high quality services including end of life care and avoidable admissions

- Home care – a) enhance in-house reablement provision to support hospital discharge and Home First strategy); b) continue development of Community Wellbeing Teams model of service to ensure home care is person-centred and flexible in meeting needs, including End of Life provision. Increase OT capacity to work with home care agencies to promote reablement principles, supporting people to regain or retain independence

- Mental Health – a) Review/maximise opportunities for commissioning services community MH services from the Third Sector, including focus on prevention and early intervention; b) Increase supported housing options, including wrap-around support for people with complex MH needs

Approaches to collaborative commissioning:

We continue to review use of BCF to ensure our pooled resources are utilised to maximum effect and are targeted at reducing health inequalities and to support people to remain living independently in their home.

The BCF is being used to enhance and develop further our out-of-hospital/community-based services, prioritising older people's services and mental health services which promote personalised care.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Since March 2020 there have been some very significant changes to hospital flows, linked to the pandemic and to the updated Hospital Discharge Guidance. This has changed the threshold and approach to care, further driving a 'discharge to assess' model, and replacing an approach based on 'medically optimised for discharge' to one more strictly defined by nationally defined 'reasons to reside'. We have embedded a daily approach to considering reasons to reside across all our acute wards, which has created more visibility on the discussions as to whether or not a patient has a need for hospital care on that date.

BCF funded activity includes all of our Intermediate Tier beds and supporting medical workforce, and funds the LCC Reablement Service, and the Leeds Community Equipment Service. These are key enablers to care at home – the Intermediate Tier beds provide a chance for further rehabilitation and recuperation for those unable to go straight home and the reablement service for those who need a period of personal care support to readjust to care at home. We have seen increased pressure on all our care at home services and equipment services, linked to an increased wish for people to be cared for at home on discharge and also at end of life.

We have recently reformed our governance structures around hospital discharge/system flow and created a System Flow Programme Board chaired by the Director of Adults and Health and the Deputy Medical Director of the CCG. This provides oversight of a number of areas of improvement, which have at their heart a more person centred and asset-based approach to discharge planning, which involves people and their families at an earlier stage and better takes into account their prior circumstances on admission. There is a detailed work plan within the hospital, the creation of a new multi-agency transfer of care hub, enhancements to our reablement service, and work on people with complex needs such as cognitive impairment or housing issues which require more focus. We are also looking at the administrative and informatics infrastructure for these services to see if we can simplify arrangements and improve tracking of system constraints. Our arrangements will ensure there is a named coordinator for people discharged with support needs, to help improve the continuity of care and provide a single point of contact for people and families if there are concerns.

The Chief Operating officer of Leeds Teaching Hospitals is the SRO for improvements in discharge within LTHT, and sits on the System Flow Programme Board. She and the Clinical Director for Specialty and Internal Medicine are leading on detailed work around to improve focus on discharge and multi-disciplinary working.

Workforce constraints remain a significant concern as of October 2021, but we are working as a system to try to maintain safe care in the most appropriate settings that we can. We have an active recruitment programme, and a detailed work plan to maximise work force which reports into our System Resilience Assurance and Reset Board ..\..\..\..\..\..\..\Desktop\workforce update October.pptx .

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Health & Housing Service within Housing Leeds promotes independent living across all tenures for disabled and vulnerable people living in our city. The service processes disabled facility grants (DFG) in the private sector in accordance with Government legislation and guidance and provides adaptations to its public sector stock funded via the Housing Revenue Account.

The service runs a comprehensive programme of discretionary funding to promote independent living, engaging with a wide variety of public, private and 3rd sector organisations to financially support projects and initiatives which promote independent living in a variety of different settings.

For individuals needing to re-house, Health and Housing can allocate medical priority on re-housing applications, has a team of Occupational Therapists who advise on suitability of prospective housing and caseworkers that support and help individuals and families locate suitable new homes to move to. Care and Repair, and Careline are both key parts of our discharge planning. We are also simplifying a pathway for people needing a 'deep clean' so that these kinds of intervention can be initiated as early as possible when the need is identified.

The Health & Housing service is fully committed to ensuring that all disabled people live in a home that is in good condition and is safe for occupation for its inhabitants ensuring everyone has full access to the property and the facilities and amenities within it.

In addition, the DFG grant is increasingly being used on integrated technology projects that enable health and social care professionals in supporting local citizens to retain their independence and remain in their own homes for longer. These include the development and roll out of the Leeds Care Record. The fund is also being used to support the delivery of the Digital Roadmap for Leeds, and in improving public and professional digital information resources relating to health and care services and in enabling social activities in our local communities.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Leeds has developed an updated system delivery plan during 20/21 which has at its heart a focus on reducing the gaps in life expectancy within our City. Covid-19 has increased this gap, and thrown into focus the differences in experience. We have not analysed the BCF indicators by ethnicity or deprivation but will look to do so in coming months. We have previously looked at ethnicity in our intermediate tier beds, which showed a lower length of stay for people from BAME communities. During Covid, we have been focused on overall safe flow and patient experience but have recently commissioned a Public health needs assessment around needs for intermediate care/care at home which will provide more granularity on the needs of individual populations and communities which will then be addressed through strategy development.

Our Mental Health Strategy has a focus on ensuring services are needs led and is focused on ensuring access to services for people in deprived communities and those people with complex mental health problems who often have physical as well as mental health needs and significantly reduced life expectancy. Within our work plans we have a key workstream looking at the variation in access between people from different communities, some of whom are underrepresented in our preventative services (outpatients and community) but overrepresented in acute beds, forensic beds, and detention under the mental health act. Our strategy also looks at the needs of older people with mental health problems whose conditions are often underdiagnosed and we have a focus also on people aged 14-25.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leeds
Completed by:	Helen Lewis, Caroline Baria, John Crowther, Richard Huskins, Lesley Newlove
E-mail:	lesley.newlove@nhs.net
Contact number:	0113 2217767

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair Leeds Health & Wellbeing Board
Name:	Councillor Fiona Venner

Has this plan been signed off by the HWB at the time of submission?	No
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 08/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Fiona	Venner	fiona.venner@leeds.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Tim	Ryley	tim.ryley@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		N/A	N/A	N/A
	Local Authority Chief Executive		Tom	Riordan	tom.riordan@leeds.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Cath	Roff	cath.roff@leeds.gov.uk
	Better Care Fund Lead Official		Helen	Lewis	helen.lewis5@nhs.net
	LA Section 151 Officer		Victoria	Bradshaw	victoria.bradshaw@leeds.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->	Better Care Fund Lead Official (Leeds City Council)		Caroline	Baria	caroline.baria@leeds.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Leeds

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£8,286,057	£8,286,057	£0
Minimum CCG Contribution	£60,996,586	£60,996,586	£0
iBCF	£30,710,369	£30,710,369	£0
Additional LA Contribution	£2,637,000	£2,637,000	£0
Additional CCG Contribution	£0	£0	£0
Total	**£102,630,012**	**£102,630,012**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£17,333,500
Planned spend	£33,041,544

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,655,042
Planned spend	£17,655,042

Scheme Types

Assistive Technologies and Equipment	£5,707,000	(5.6%)
Care Act Implementation Related Duties	£1,900,000	(1.9%)
Carers Services	£2,133,445	(2.1%)
Community Based Schemes	£0	(0.0%)
DFG Related Schemes	£8,286,057	(8.1%)
Enablers for Integration	£467,050	(0.5%)
High Impact Change Model for Managing Transfer of	£25,527,294	(24.9%)
Home Care or Domiciliary Care	£0	(0.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£13,374,704	(13.0%)
Reablement in a persons own home	£2,807,000	(2.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£10,690,555	(10.4%)
Residential Placements	£30,710,369	(29.9%)
Other	£1,026,538	(1.0%)
Total	**£102,630,012**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	tbc	810.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	13.5%	13.0%
	LOS 21+	7.0%	7.0%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	0.0%	76.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	461	550

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	82.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Leeds

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leeds	£8,286,057
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£8,286,057**

iBCF Contribution	Contribution
Leeds	£30,710,369
Total iBCF Contribution	**£30,710,369**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Leeds	£2,637,000	Equipment service contribution
Total Additional Local Authority Contribution	**£2,637,000**	

CCG Minimum Contribution	Contribution
NHS Leeds CCG	£60,996,586
Total Minimum CCG Contribution	**£60,996,586**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£60,996,586**	

	2021-22
Total BCF Pooled Budget	**£102,630,012**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Leeds

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£8,286,057	£8,286,057	£0
Minimum CCG Contribution	£60,996,586	£60,996,586	£0
iBCF	£30,710,369	£30,710,369	£0
Additional LA Contribution	£2,637,000	£2,637,000	£0
Additional CCG Contribution	£0	£0	£0
Total	**£102,630,012**	**£102,630,012**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£17,333,500	£33,041,544	£0
Adult Social Care services spend from the minimum CCG allocations	£17,655,042	£17,655,042	£0

Checklist

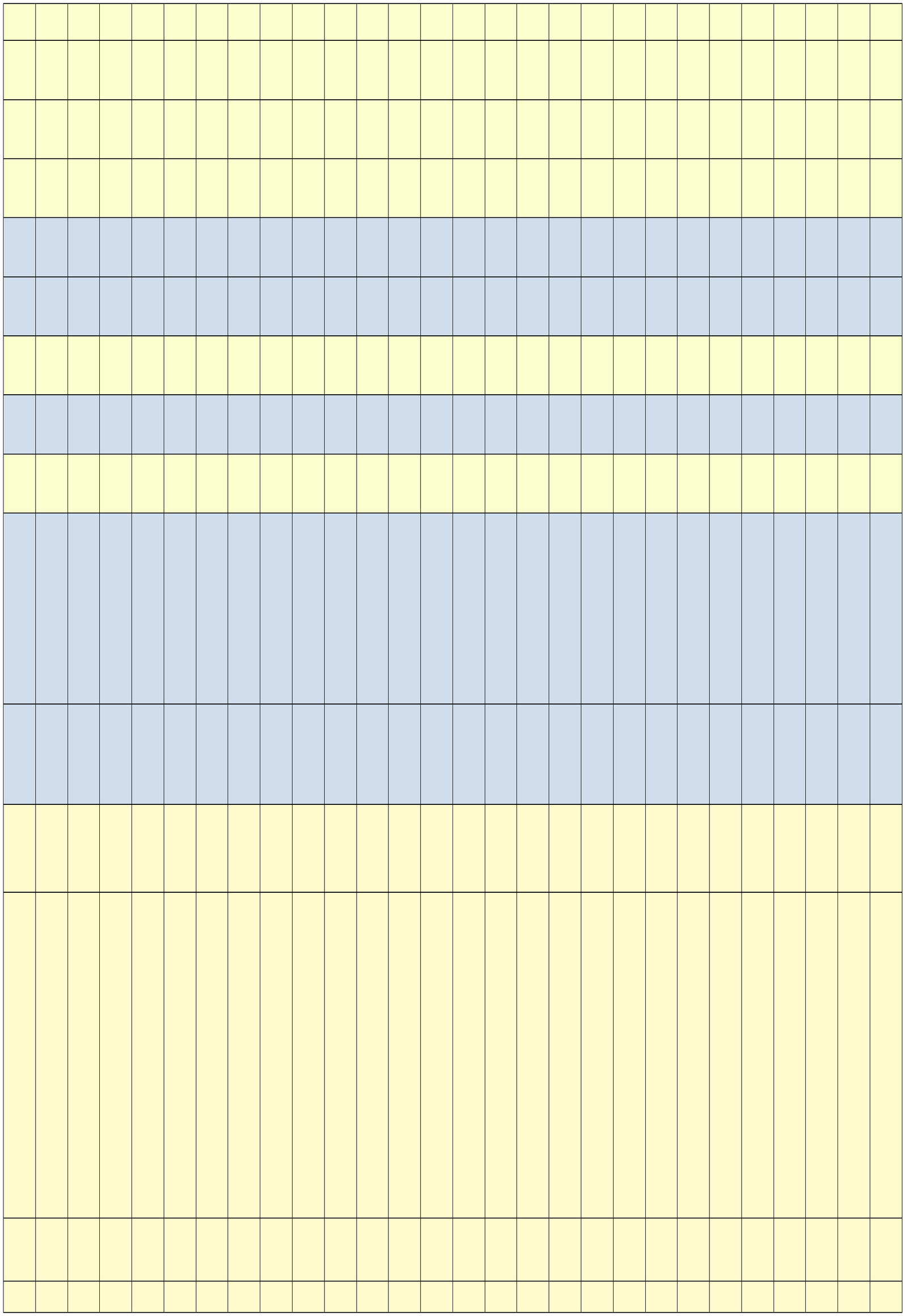
Column complete:

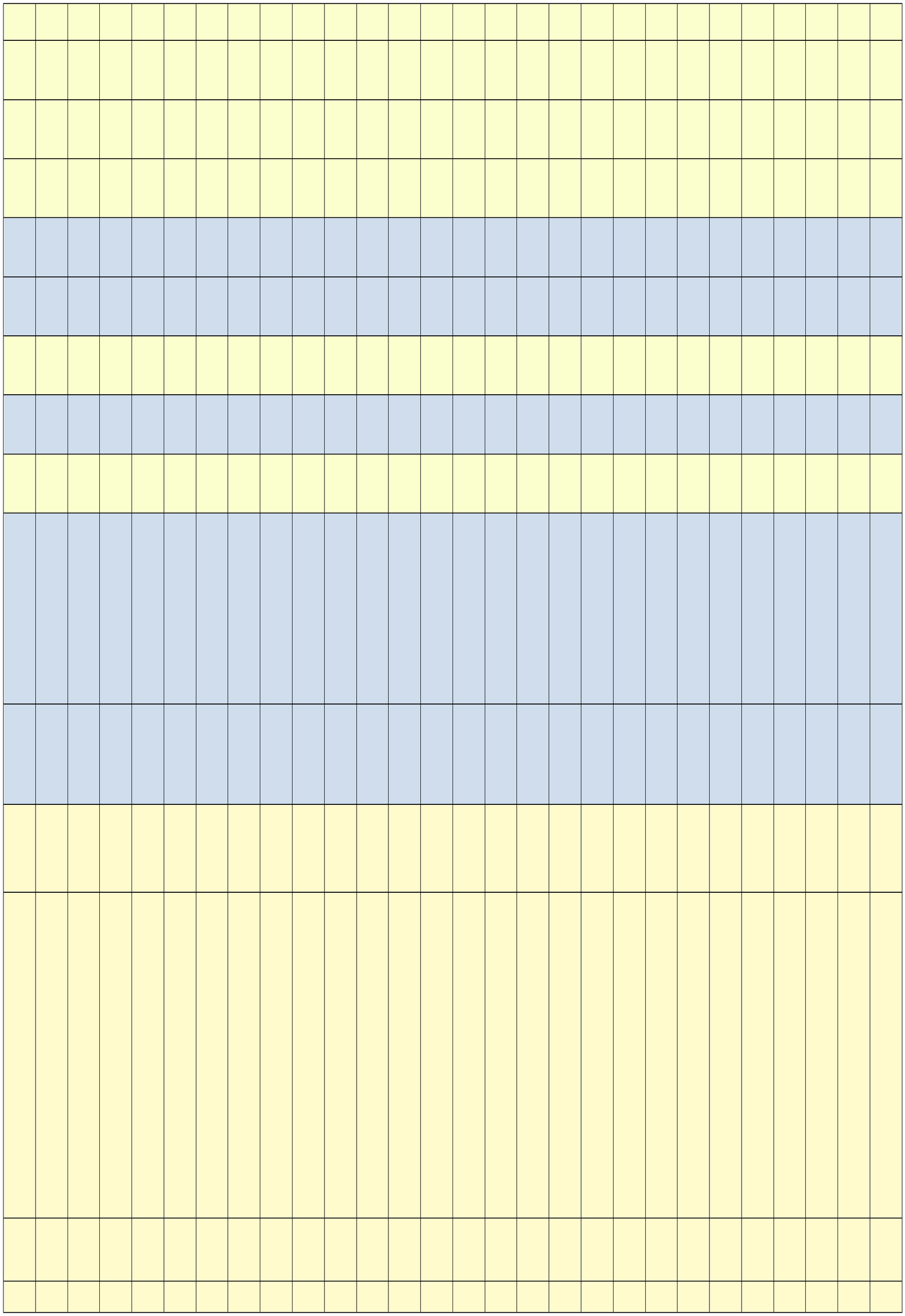
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

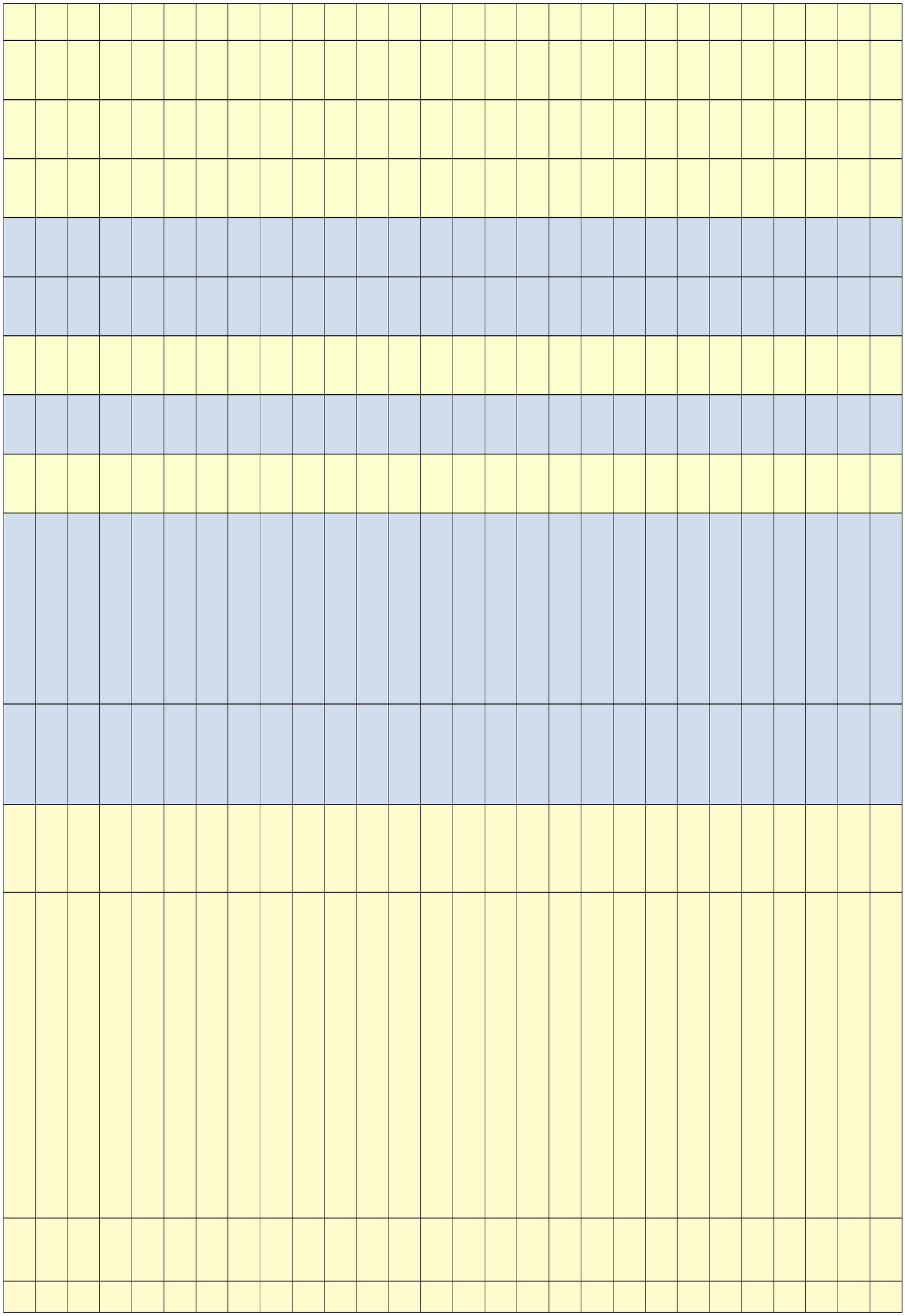
Sheet complete

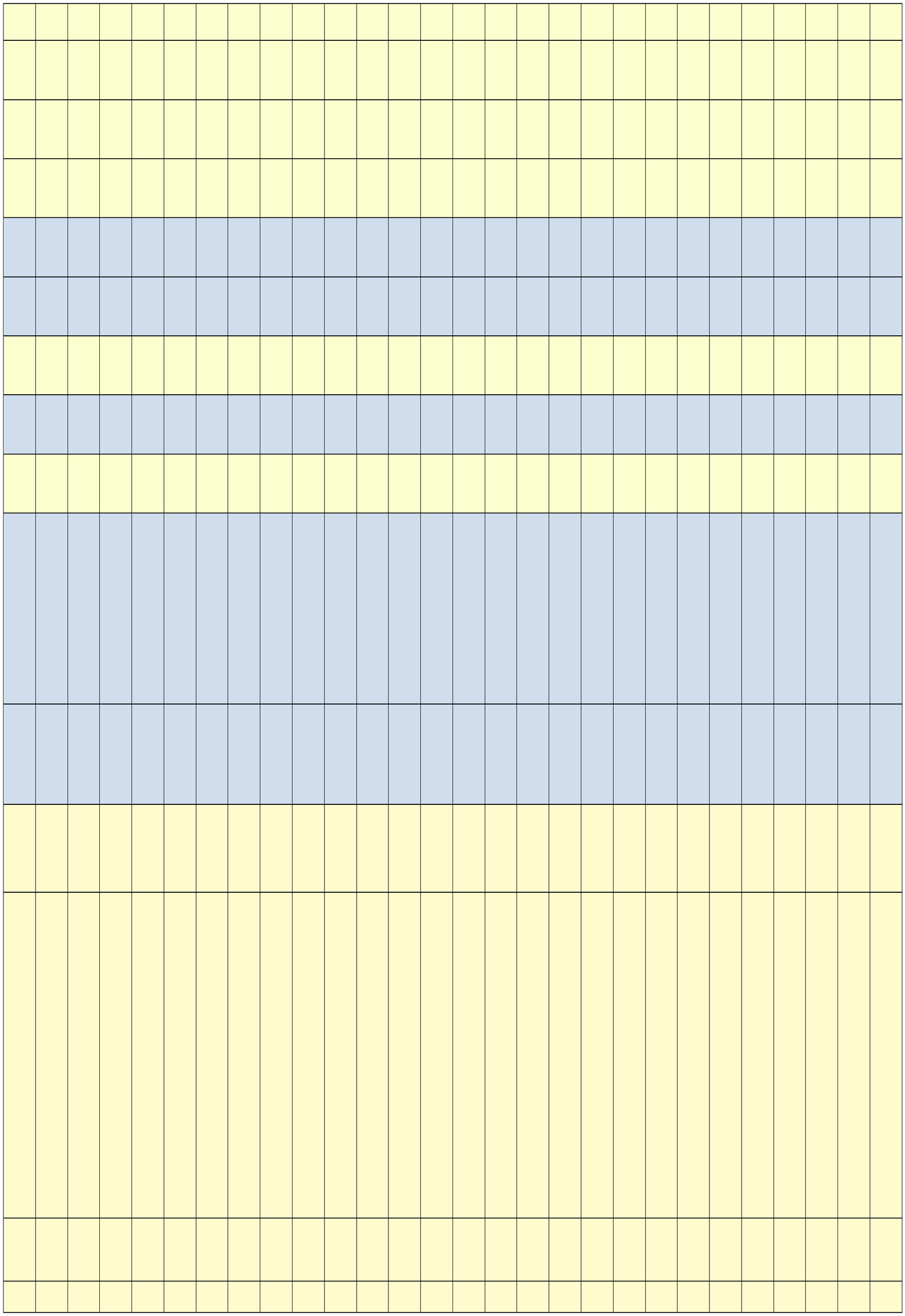
						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
400	Reablement Services	Reablement services	Reablement in a persons own home	Preventing admissions to acute setting		Community Health		CCG			Local Authority	Minimum CCG Contribution	£2,807,000	Existing
401	Community beds	The community beds service provides intermediate care in the community	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum CCG Contribution	£11,968,219	Existing
402	Community beds	The Green	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Local Authority	Minimum CCG Contribution	£1,406,485	Existing
418	Supporting carers	A range of services to support carers	Carers Services	Other	Carer advice and support	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,501,709	Existing
403	Supporting carers	A range of services to support carers	Carers Services	Respite services		Continuing Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£278,126	Existing
404	Supporting carers	A range of services to support carers	Carers Services	Respite services		Community Health		CCG			Local Authority	Minimum CCG Contribution	£353,610	Existing
405	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Local Authority	Minimum CCG Contribution	£3,070,000	Existing
406	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Local Authority	Additional LA Contribution	£2,637,000	Existing
419	3rd Sector prevention	Mental Health Prevention Services	Prevention / Early Intervention	Other	Mental Health Prevention Services	Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£5,443,440	Existing
420	3rd Sector prevention	Community Health Prevention Services	Prevention / Early Intervention	Other	Community Healt Prevention Services	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£505,911	Existing
407	Admission avoidance	Crisis support/diversion from hospital	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Service to ensure people who are admitted to hospital are managed appropriately on discharge to support them to live at home and avoid re-admission	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£2,800,000	Existing
408	Community Matrons	Health Care in the community	Prevention / Early Intervention	Other	Health care in the community	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,600,000	Existing
409	Homeless Accommodation Leeds Pathway (HALP)	To provide transitional accommodation for homeless patients after a stay in hospital	Other		To provide dedicated beds at St George's Crypt to provide transitional accommodation for homeless patients to facilitate timely discharge after a stay in hospital	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£303,790	Existing
410	Interface Geriatricians	Community Geriatrician service to deliver a consultant led; community facing service for frail elderly patients providing direct patient care to patients and, direct clinical advice and support to the Neighbourhood Teams, and Primary Care.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£195,000	Existing

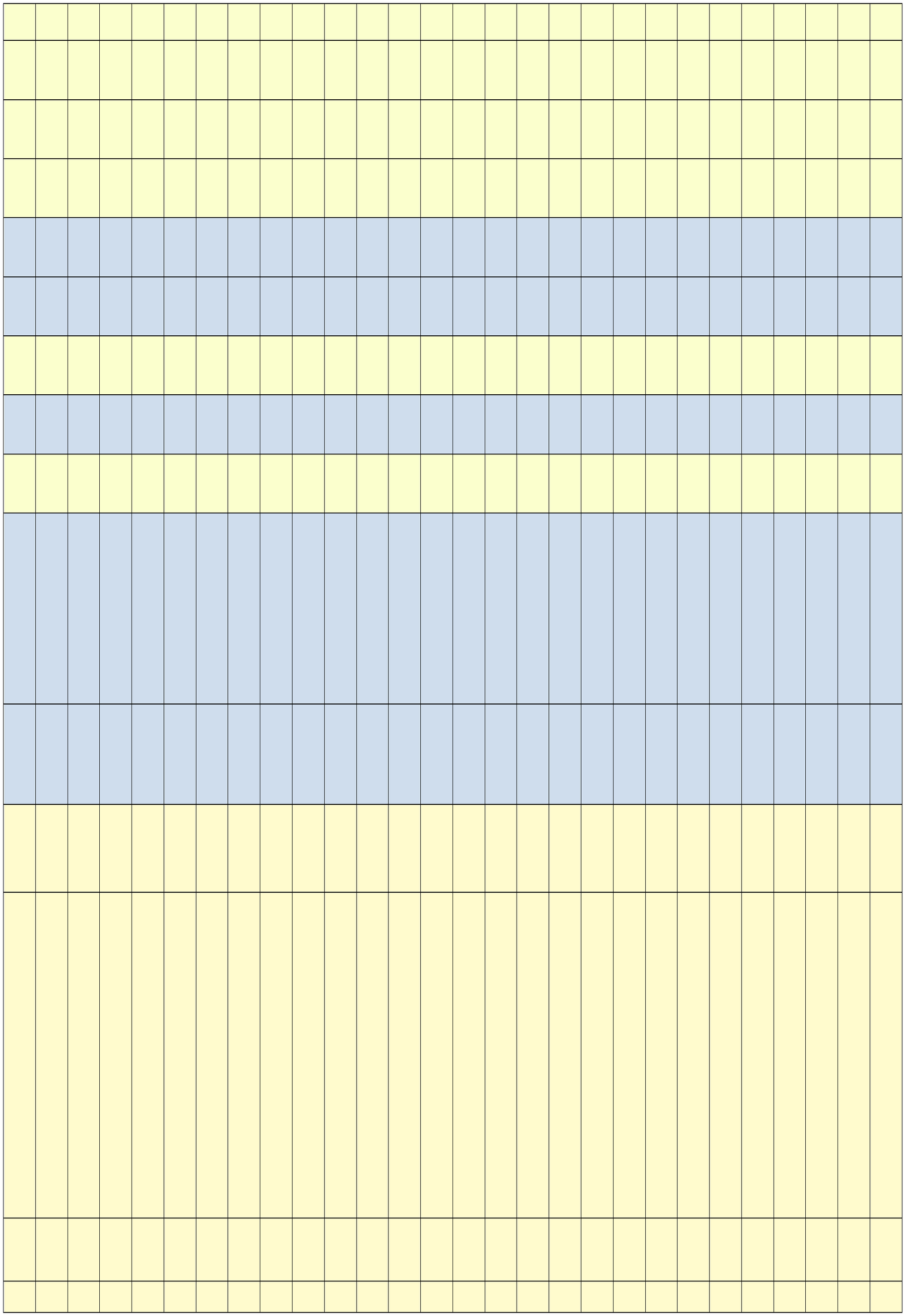
411	Disabled Facilities Grant	Means-tested grant to cover the cost of housing adaptations that help disabled people to live independently in their own homes	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£8,286,057	Existing
412	Social Care to Health Benefit	Social care to health benefit	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Funding for social care to benefit health services	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£15,032,294	Existing
413	Contingency	Contingency fund	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Contingency set aside for any NEA shortfall	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£7,500,000	Existing
414	Care Bill	To cover the financial costs associated with the Care Act	Care Act Implementation Related Duties	Other	To cover the financial costs associated with the Care Act	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,900,000	Existing
415	Enhancing Primary care	Primary care developments with the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding is used to enhance services to support the management of this patient cohort.	Prevention / Early Intervention	Risk Stratification		Primary Care		CCG			CCG	Minimum CCG Contribution	£2,141,204	Existing
416	Information Technology	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.	Enablers for Integration	System IT Interoperability	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.	Other	Charity	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£467,050	Existing
417	Former local reform and Community voices	Former local reform and community voices grant	Other	Former local reform and community voices grant	A former social care grant transferred into the BCF	Social Care		LA			Local Authority	Minimum CCG Contribution	£150,000	Existing
421	Contribution to social care demand pressures	Contribution to social care demand pressures	Residential Placements	Other	Contribution to social care demand pressures	Social Care		LA			Local Authority	iBCF	£30,710,369	Existing
500	Social Care to Health Benefit	Social Care to Health Benefit	Other		Additional contribution	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£572,748	New

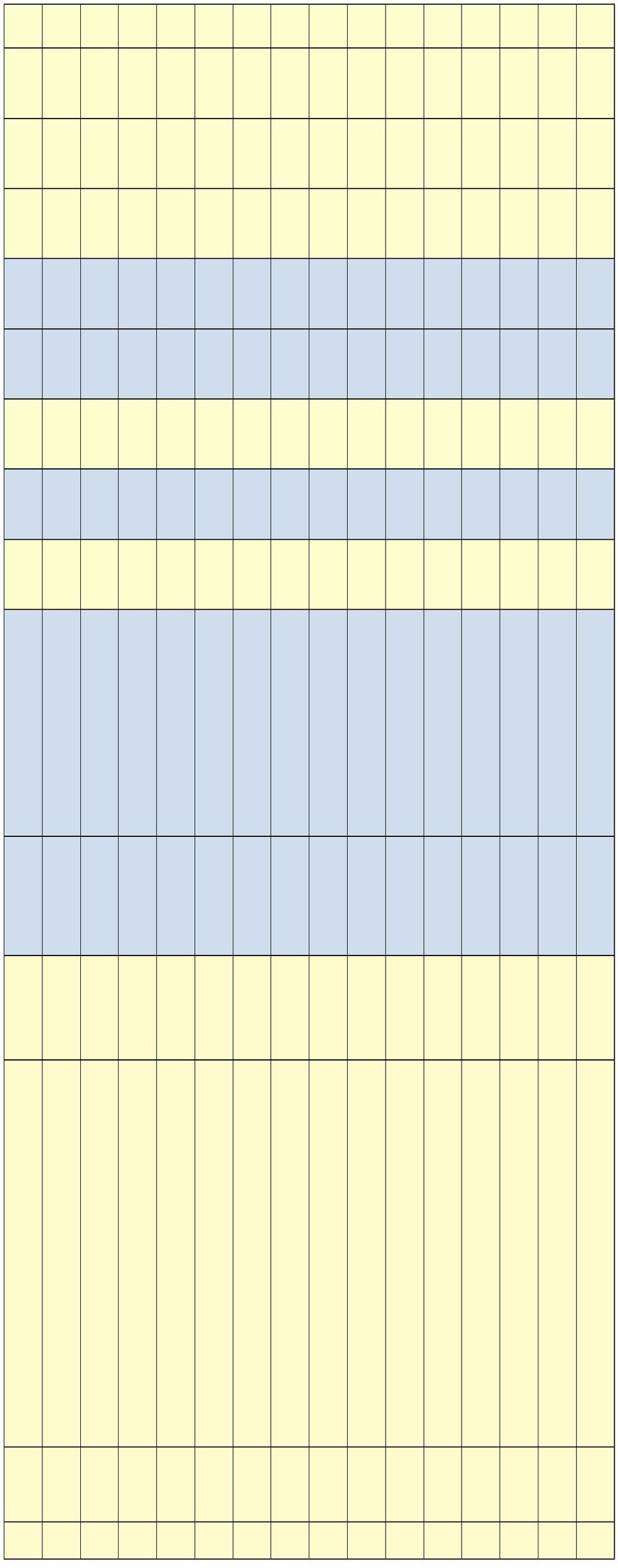












2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Leeds

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		tbc	810.0	Leeds rates are below national in 19/20 (816/100,000) compared to 862. They have declined steadily since 2015. We know 20/21 will be an anomalous year, but we expect a further small decline in 21/22 as we have enhanced our Medical Same Day Emergency Response offer from mid-year and expanded our Virtual Ward/urgent community response. Proactive care, and enhanced care in care homes should also further reduce admissions in this cohort. The data for 20/21 is not available, but is not considered to be relevant because it was such an anomalous year. Our current admission rate is tracking 20/21 admission rates, despite the growth in demand, which is showing the impact of our front door changes.	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	13.5%	13.0%	The BCF measure is place based, and measured on people discharged each month, whereas the weekly national Tableau report is provider based and based on incomplete pathways. While LTHT has a high proportion of people over 21 days LOS in its incomplete pathways, Leeds as a place is less of an outlier in completed pathways. Based on the BCF measure, we aim to reduce maintain our September levels of discharges over 14 days in Q3 and improve this by 0.5% in Q4 and to improve by 0.4% for 21 days plus in Q3 and then sustain that in Q4. We have some additional care home and community capacity opening in December, which should help improve Q3 overall, but we are mindful of the growth in no reason to reside patients we have seen during October and November. We are making some improvements in pathway which should reduce some of the avoidable delays in our transfer of care process. However, we are exceptionally aware that whatever process improvements we put in, the local social care workforce pressures are growing, which is likely in turn to increase the tip of some patients into the over 14 and over 21 day categories. The key actions to enable these improvements are: • Earlier discharge planning in hospital wards driven by the improvement work, which should help reduce overall length of stay for those patients not requiring support on discharge, and contribute to improvements for those requiring that support • Improvements in reablement ensuring that same day/next day capacity is available which should help minimise delays (if recruitment improves) • Improvements in transfer of care arrangements to ensure that there is earlier transfer to intermediate tier or care at home options once patients no longer have a reason to reside • Improved work between hospital and community therapies encouraging earlier transfers of people needing ongoing therapy/mobilisation • Improved staffing and engagement with the Intermediate Tier beds to enable care for more people with greater needs such as assistance of 2 Additional beds for winter (but likely to offset growth rather than improve numbers overall) Additional SW recruitment Removal of the stays within the Villa Care wards from the LTHT discharge data should also slightly reduce the numbers of discharges each month which are longer lengths of stay compared to historic volumes. We are also improving the way in which our Transfer of Care Hub communicates with the wards to increase the timeliness of transfers once packages/placements are confirmed. The major risks to delivering this ambition or going further are the significant workforce pressures now in the system, which have substantially reduced flow both to care at home and to care home placements. We have already seen two homes close/restrict admissions, which has added further pressure to a stressed system. While the system remains focused on workforce and recruitment, the significant pay and recruitment issues remain a major risk to delivery which will further impact on length of stay across all settings. The reduction in our short stay acute episodes (see below) via our admission avoidance work, also impacts on the proportions of people who require a longer length of stay or are delayed due to outflow issues as a proportion of the total.	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	7.0%	7.0%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
			Please set out the overall plan in the HWB area for

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	76.0%	We aim to return to 2019 levels of people discharged to their usual place of residence as our elective activity increases, and our deaths and intermediate tier discharges stabilise. Our ambition to reduce transfers to supported settings is tempered by an understanding of the home care staffing issues in the coming months which may require a reduction in 'home first' to enable flow. We are establishing a multi-agency transfer of care hub that is further supporting a 'home first' ethos, in conjunction with VCSE colleagues.	**improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	564	561	461	550	2020/21 admission numbers were impacted upon by the COVID pandemic which led to lower than expected admission levels. It is expected that admission levels for 2021/22 will be more in line with levels seen in 2019/20.	**Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	700	693	571	690		
	Denominator	124,017	123,516	123,784	125,529		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England: https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%	83.1%	82.0%	2021/22 performance is expected to be broadly in line with pre-pandemic levels in 2019/20. The service is seeing an increased volume of people which is shown in the activity levels.	**Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	425	276	574		
	Denominator	500	332	700		

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Leeds

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Supporting narrative. HWB Chair to sign off before final submission, with narrative to HWB in December for ratification. Single HWB. Plan developed by LCC and NHS Officers jointly and reviewed by Chief Officers		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leeds
Completed by:	Helen Lewis, Caroline Baria, John Crowther, Richard Huskins, Lesley Newlove
E-mail:	lesley.newlove@nhs.net
Contact number:	0113 2217767

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair Leeds Health & Wellbeing Board
Name:	Councillor Fiona Venner

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 06/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Fiona	Venner	fiona.venner@leeds.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Tim	Ryley	tim.ryley@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		N/A	N/A	N/A
	Local Authority Chief Executive		Tom	Riordan	tom.riordan@leeds.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Cath	Roff	cath.roff@leeds.gov.uk
	Better Care Fund Lead Official		Helen	Lewis	helen.lewis5@nhs.net
	LA Section 151 Officer		Victoria	Bradshaw	victoria.bradshaw@leeds.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->	Better Care Fund Lead Official (Leeds City Council)		Caroline	Baria	caroline.baria@leeds.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Leeds

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£8,286,057	£8,286,057	£0
Minimum CCG Contribution	£60,996,586	£60,996,586	£0
iBCF	£30,710,369	£30,710,369	£0
Additional LA Contribution	£2,637,000	£2,637,000	£0
Additional CCG Contribution	£0	£0	£0
Total	**£102,630,012**	**£102,630,012**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£17,333,500
Planned spend	£33,041,544

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,655,042
Planned spend	£17,655,042

Scheme Types

Assistive Technologies and Equipment	£5,707,000	(5.6%)
Care Act Implementation Related Duties	£1,900,000	(1.9%)
Carers Services	£2,133,445	(2.1%)
Community Based Schemes	£0	(0.0%)
DFG Related Schemes	£8,286,057	(8.1%)
Enablers for Integration	£467,050	(0.5%)
High Impact Change Model for Managing Transfer of	£25,527,294	(24.9%)
Home Care or Domiciliary Care	£0	(0.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£13,374,704	(13.0%)
Reablement in a persons own home	£2,807,000	(2.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£10,690,555	(10.4%)
Residential Placements	£30,710,369	(29.9%)
Other	£1,026,538	(1.0%)
Total	**£102,630,012**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	815.0	810.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	13.5%	13.0%
	LOS 21+	7.0%	7.0%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	0.0%	76.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	461	550

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	82.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Leeds

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leeds	£8,286,057
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£8,286,057**

iBCF Contribution	Contribution
Leeds	£30,710,369
Total iBCF Contribution	**£30,710,369**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Leeds	£2,637,000	Equipment service contribution
Total Additional Local Authority Contribution	**£2,637,000**	

CCG Minimum Contribution	Contribution
NHS Leeds CCG	£60,996,586
Total Minimum CCG Contribution	**£60,996,586**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£60,996,586**	

	2021-22
Total BCF Pooled Budget	**£102,630,012**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Leeds

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£8,286,057	£8,286,057	£0
Minimum CCG Contribution	£60,996,586	£60,996,586	£0
iBCF	£30,710,369	£30,710,369	£0
Additional LA Contribution	£2,637,000	£2,637,000	£0
Additional CCG Contribution	£0	£0	£0
Total	**£102,630,012**	**£102,630,012**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£17,333,500	£33,041,544	£0
Adult Social Care services spend from the minimum CCG allocations	£17,655,042	£17,655,042	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
400	Reablement Services	Reablement services	Reablement in a persons own home	Preventing admissions to acute setting		Community Health		CCG			Local Authority	Minimum CCG Contribution	£2,807,000	Existing
401	Community beds	The community beds service provides intermediate care in the community	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum CCG Contribution	£11,968,219	Existing
402	Community beds	The Green	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Local Authority	Minimum CCG Contribution	£1,406,485	Existing
418	Supporting carers	A range of services to support carers	Carers Services	Other	Carer advice and support	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,501,709	Existing
403	Supporting carers	A range of services to support carers	Carers Services	Respite services		Continuing Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£278,126	Existing
404	Supporting carers	A range of services to support carers	Carers Services	Respite services		Community Health		CCG			Local Authority	Minimum CCG Contribution	£353,610	Existing
405	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Local Authority	Minimum CCG Contribution	£3,070,000	Existing
406	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Local Authority	Additional LA Contribution	£2,637,000	Existing
419	3rd Sector prevention	Mental Health Prevention Services	Prevention / Early Intervention	Other	Mental Health Prevention Services	Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£5,443,440	Existing
420	3rd Sector prevention	Community Health Prevention Services	Prevention / Early Intervention	Other	Community Healt Prevention Services	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£505,911	Existing
407	Admission avoidance	Crisis support/diversion from hospital	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Service to ensure people who are admitted to hospital are managed appropriately on discharge to support them to live at home and avoid re-admission	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£2,800,000	Existing
408	Community Matrons	Health Care in the community	Prevention / Early Intervention	Other	Health care in the community	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,600,000	Existing
409	Homeless Accommodation Leeds Pathway (HALP)	To provide transitional accommodation for homeless patients after a stay in hospital	Other		To provide dedicated beds at St George's Crypt to provide transitional accommodation for homeless patients to facilitate timely discharge after a stay in hospital	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£303,790	Existing
410	Interface Geriatricians	Community Geriatrician service to deliver a consultant led; community facing service for frail elderly patients providing direct patient care to patients and, direct clinical advice and support to the Neighbourhood Teams, and Primary Care.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£195,000	Existing

411	Disabled Facilities Grant	Means-tested grant to cover the cost of housing adaptations that help disabled people to live independently in their own homes	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£8,286,057	Existing
412	Social Care to Health Benefit	Social care to health benefit	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Funding for social care to benefit health services	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£15,032,294	Existing
413	Contingency	Contingency fund	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Contingency set aside for any NEA shortfall	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£7,500,000	Existing
414	Care Bill	To cover the financial costs associated with the Care Act	Care Act Implementation Related Duties	Other	To cover the financial costs associated with the Care Act	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,900,000	Existing
415	Enhancing Primary care	Primary care developments with the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding is used to enhance services to support the management of this patient cohort.	Prevention / Early Intervention	Risk Stratification		Primary Care		CCG			CCG	Minimum CCG Contribution	£2,141,204	Existing
416	Information Technology	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.	Enablers for Integration	System IT Interoperability	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.	Other	Charity	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£467,050	Existing
417	Former local reform and Community voices	Former local reform and community voices grant	Other	Former local reform and community voices grant	A former social care grant transferred into the BCF	Social Care		LA			Local Authority	Minimum CCG Contribution	£150,000	Existing
421	Contribution to social care demand pressures	Contribution to social care demand pressures	Residential Placements	Other	Contribution to social care demand pressures	Social Care		LA			Local Authority	iBCF	£30,710,369	Existing
500	Social Care to Health Benefit	Social Care to Health Benefit	Other		Additional contribution	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£572,748	New

2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Leeds

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		815.0	810.0	No nationally updated data has been provided for the 2020 rates, and we do not have the ability locally to run reports based on local authority area rather than CCG from HES data. We are therefore assuming that our 2020 rate was in line with our 2019 rate. It may in fact have been lower, given the impact of Covid restrictions on non-Covid presentations but we do not have the detail on this, and do not think it is relevant for 2021 rates given the anomalous situation of 2020. Leeds rates are below national in 19/20 (816/100,000) compared to 862. They have declined steadily since 2015. We know 20/21 will be an anomalous year, but we expect a further small decline in 21/22 as we have enhanced our Medical Same Day Emergency Response offer from mid-year and expanded our Virtual Ward/urgent community response. Proactive care, and enhanced care in care homes should also further reduce admissions in this cohort. The data for 20/21 is not available, but is not considered to be relevant because it was such an anomalous year. Our current admission rate is tracking 20/21 admission rates, despite the growth in demand, which is showing the impact of our front door changes.	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	13.5%	13.0%	The BCF measure is place based, and measured on people discharged each month, whereas the weekly national Tableau report is provider based and based on incomplete pathways. While LTHT has a high proportion of people over 21 days LOS in its incomplete pathways, Leeds as a place is less of an outlier in completed pathways. Based on the BCF measure, we aim to reduce maintain our September levels of discharges over 14 days in Q3 and improve this by 0.5% in Q4 and to improve by 0.4% for 21 days plus in Q3 and then sustain that in Q4. We have some additional care home and community capacity opening in December, which should help improve Q3 overall, but we are mindful of the growth in no reason to reside patients we have seen during October and November. We are making some improvements in pathway which should reduce some of the avoidable delays in our transfer of care process. However, we are exceptionally aware that whatever process improvements we put in, the local social care workforce pressures are growing, which is likely in turn to increase the tip of some patients into the over 14 and over 21 day categories. The key actions to enable these improvements are: •Earlier discharge planning in hospital wards driven by the improvement work, which should help reduce overall length of stay for those patients not requiring support on discharge, and contribute to improvements for those requiring that support •Improvements in reablement ensuring that same day/next day capacity is available which should help minimise delays (if recruitment improves) •Improvements in transfer of care arrangements to ensure that there is earlier transfer to intermediate tier or care at home options once patients no longer have a reason to reside •Improved work between hospital and community therapies encouraging earlier transfers of people needing ongoing therapy/mobilisation •Improved staffing and engagement with the Intermediate Tier beds to enable care for more people with greater needs such as assistance of 2 Additional beds for winter (but likely to offset growth rather than improve numbers overall) Additional SW recruitment Removal of the stays within the Villa Care wards from the LTHT discharge data should also slightly reduce the numbers of discharges each month which are longer lengths of stay compared to historic volumes. We are also improving the way in which our Transfer of Care Hub communicates with the wards to increase the timeliness of transfers once packages/placements are confirmed. The major risks to delivering this ambition or going further are the significant workforce pressures now in the system, which have substantially reduced flow both to care at home and to care home placements. We have already seen two homes close/restrict admissions, which has added further pressure to a stressed system. While the system remains focused on workforce and recruitment, the significant pay and recruitment issues remain a major risk to delivery which will further impact on length of stay across all settings. The reduction in our short stay acute episodes (see below) via our admission avoidance work, also impacts on the proportions of people who require a longer length of stay or are delayed due to outflow issues as a proportion of the total. The ambitions around length of stays have been debated by our Silver Group of Chief Operating Officers from hospital, community trust and Adult Social Care, and we have debated closely the ability to influence these materially in the light of the local social care workforce market. We have been relatively cautious because we are very aware of the local context. However, we remain ambitious to drive out any delays that are not capacity dependent. Although the BCF measures only focus on length of stay in acute providers, we are equally mindful of delays in our mental health providers not only in older people but in working age adults, and continue to focus our resources and attention on these too.	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	7.0%	7.0%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	76.0%	We aim to return to 2019 levels of people discharged to their usual place of residence as our elective activity increases, and our deaths and intermediate tier discharges stabilise. Our ambition to reduce transfers to supported settings is tempered by an understanding of the home care staffing issues in the coming months which may require a reduction in 'home first' to enable flow. We are establishing a multi-agency transfer of care hub that is further supporting a 'home first' ethos, in conjunction with VCSE colleagues. All our trajectories are interlinked – any action that reduces length of stay will have a potential impact on any of the other measures. We remain committed to ensuring patients leave hospital as soon as possible, access reablement wherever possible, and avoid admission to long term care through intensive reablement, rehabilitation, appropriate equipment, home adaptations, good medical cover etc. All of these are within our BCF schemes – we are not focused on 'schemes' per se as we see these as a range of service offers, geared to meet the needs of individuals. We have, for example, provided additional funding to change the skill mix in our Community Care Beds to enable people with more demanding behaviours to access a therapeutic environment. Our BCF also includes funding for primary care to ensure there are no avoidable readmissions to hospital, and to reduce the likelihood of declines requiring long term care admissions. We have significantly invested in night sitters and care at home more broadly, but some of this investment in 21/22 has been through hospital discharge fund rather than BCF.	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	564	561	461	550	2020/21 admission numbers were impacted upon by the COVID pandemic which led to lower than expected admission levels. It is expected that admission levels for 2021/22 will be more in line with levels seen in 2019/20.	**Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	700	693	571	690		
	Denominator	124,017	123,516	123,784	125,529		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England: https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%	83.1%	82.0%	2021/22 performance is expected to be broadly in line with pre-pandemic levels in 2019/20. The service is seeing an increased volume of people which is shown in the activity levels.	**Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**
	Numerator	425	276	574		
	Denominator	500	332	700		

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Leeds

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Supporting narrative. HWB Chair has signed off the plan with delegated authority from the HWB. The plan is to be ratified at a public HWB meeting on 6th December 2021. Single HWB. Plan developed by LCC and NHS Officers jointly and reviewed by Chief Officers		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Leeds Health and Wellbeing Board

Report author: Judith Williams
Tel: 0113 221 7823

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

Report to: Leeds Health and Wellbeing Board

Date: 6th December 2021

Subject: Leeds Health and Care Financial Reporting at end of September 2021 (M6 2021/22)

Strapline: Overview of the financial positions of the health and care organisations in Leeds

Comms & Engagement: Please provide 3 key points that you would want to communicate with the public about this paper / item for use on social media to promote engagement with this meeting
N/A

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This report provides the Health and Wellbeing Board with an overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide financial report (Appendix 1)

NHS organisations continue to operate under a revised financial regime due to the covid pandemic. This includes planning and funding arrangements only being confirmed initially for the first 6 months of the financial year, known as the H1 period. Therefore, there is no full year forecast position provided at this point.

Financial plans for October to March 2022 (H2 2021/22) for NHS organisations across the region are due to be submitted to NHSEI , via the West Yorkshire and Harrogate Integrated Care System (WY &H ICS), on 22nd November 2021.

At the end of September 2021, the position across the three Leeds NHS providers was a small surplus, The CCG reported an overspend of £2m, prior to anticipated retrospective reimbursements for covid out of envelope items such as the Hospital Discharge Programme (HDP). This funding is subject to validation by NHSEI and given quarterly in arrears. The allocations have subsequently been confirmed and bring the CCG to a breakeven position.

Leeds City Council (LCC) has also been impacted by the covid pandemic with Childrens & Families reporting a projected overspend of £8.99m at the end of September, this mostly relates to a £6.5m overspend for Children Looked After (CLA) and non-CLA placements. Adult Social Care have a balanced position at M6 but with pressures going into winter which will impact both the NHS and Social Care workforce.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the M6 2021/22 partner financial positions
- Note the financial plan submission for H2 2021/22 for NHS organisations

1 Purpose of this report

1.1 This report provides the Health and Wellbeing Board with a brief overview of the financial positions of the health and care organisations in Leeds, brought together to provide a single citywide financial report (Appendix 1). This report is for the period ending September 2021.

1.2 Together, this financial information and associated narrative aims to provide a greater understanding of the collective and individual financial performance of the health and care organisations in Leeds. This provides the Health and Wellbeing Board with an opportunity to direct action which will support an appropriate and effective response.

1.3 This paper supports the Board's role in having strategic oversight of both the financial sustainability of the Leeds health and care system and of the executive function carried out by the Partnership Executive Group (PEG).

2 Background information

2.1 The financial information contained within this report has been contributed by Directors of Finance from Leeds City Council (LCC), Leeds Community Healthcare Trust (LCH), Leeds Teaching Hospital Trust (LTHT), Leeds and York Partnership Trust (LYPFT) and NHS Leeds Clinical Commissioning Group (CCG).

3 Main issues

3.1 NHS organisations continue to operate under a revised financial regime due to the covid pandemic

3.2 This includes planning and funding arrangements only being agreed initially for the first 6 months of the financial year, known as the H1 period. Therefore, there is no full year forecast position provided at this point.

3.3 The plans for NHS organisations in Leeds collectively for the H1 period demonstrated a break-even position

3.4 At the end of M6 2021/22 there was a small surplus position across the 3 NHS providers in Leeds, and an overspend of £2m shown at the CCG, before retrospective reimbursement of Q2 covid out of envelope items such as the Hospital Discharge Programme. This funding has subsequently been confirmed resulting in the CCG achieving break even.

3.5 Leeds City Council (LCC) has also been impacted by the covid pandemic with Childrens & Families reporting a projected overspend of £8.99m at the end of September, this mostly relates to a £6.5m overspend for Children Looked After (CLA) and non-CLA placements. Adult Social Care have a balanced position at M6 but with pressures going into winter which will impact both the NHS and Social Care workforce.

3.6 Financial plans for October to March 2022 (H2 2021/22) for NHS organisations across the region are due to be submitted to NHSEI, via the West Yorkshire and Harrogate Integrated Care System (WY &H ICS), on 22nd November

4 Health and Wellbeing Board governance

4.1 Consultation, engagement, and hearing citizen voice

4.1.1 Development of the Leeds health & care quarterly financial report is overseen by the Directors of Finance and equivalents from Leeds City Council, Leeds Community Healthcare Trust, Leeds Teaching Hospital Trust, Leeds and York Partnership Trust and the Leeds Clinical Commissioning Group.

4.1.2 Individual organisations engage with citizens through their own internal process and spending priorities are aligned to the Leeds Health and Wellbeing Strategy 2016-2021, which was developed through significant engagement activity.

4.2 Equality and diversity / cohesion and integration

4.2.1 Through the Leeds health & care quarterly financial report we are better able to understand a citywide position and identify challenges and opportunities across the health and care system to contribute to the delivery of the vision that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest', which underpins the Leeds Health and Wellbeing Strategy 2016-2021.

4.3 Resources and value for money

4.3.1 The Health and Wellbeing Board has oversight of the financial stability of the Leeds system with PEG committed to using the 'Leeds £', our money and other resources, wisely for the good of the people we serve in a way in which also balances the books for the city. Bringing together financial updates from health and care organisations in a single place has multiple benefits; we are better able to understand a citywide position, identify challenges and opportunities across the health and care system and ensure that people of Leeds are getting good value for the collective Leeds £.

4.4 Legal Implications, access to information and call In

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

4.5 Risk management

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

5 Conclusions

5.1 There continues to be significant challenges and risks across the system, with recurrent and non recurrent additional costs related to the covid pandemic. But also, significant non recurrent funding available in this period, Workforce capacity also remains an issue.

5.2 The NHS organisations across Leeds end the H1 period with a small collective surplus. Leeds City Council are reporting a £9m overspend at the end of September 2021.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the M6 2021/22 partner financial positions
- Note the financial plan submission for H2 2021/22 for NHS organisations

7 Background documents

7.1 None

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
An efficient health and care system in financial balance enables us to use resources more effectively and target these in areas of greatest need

How does this help create a high quality health and care system?
Driving up quality depends on having the resources to meet the health and care needs of the people of Leeds. Spending every penny wisely on evidence-based interventions and ensuring we have an appropriate workforce and can manage our workforce effectively promotes system-wide sustainability

How does this help to have a financially sustainable health and care system?
It maintains visibility of the financial position of the statutory partners in the city

Future challenges or opportunities
Future updates will be brought to the Health and Wellbeing Board as requested and should be factored into the work plan of the Board

Priorities of the Leeds Health and Wellbeing Strategy 2016-21 (please tick all that apply to this report)	
A Child Friendly City and the best start in life	x
An Age Friendly City where people age well	x
Strong, engaged and well-connected communities	x
Housing and the environment enable all people of Leeds to be healthy	x
A strong economy with quality, local jobs	x
Get more people, more physically active, more often	x
Maximise the benefits of information and technology	x
A stronger focus on prevention	x
Support self-care, with more people managing their own conditions	x
Promote mental and physical health equally	x
A valued, well trained and supported workforce	x
The best care, in the right place, at the right time	x

Appendix 1 - Finance Report to the Leeds Health and Wellbeing Board as at end of September 2021 (H1 2021/22)

Outturn for 6 months ended 30th September 2021	Total Income/Funding			Pay Costs			Other Costs			Total Costs			Net surplus/(deficit)		
	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Leeds City Council - Adult Social Care	173.08	192.54	19.46	58.01	57.72	0.29	310.28	330.03	(19.75)	368.29	387.75	(19.46)	(195.21)	(195.21)	0.00
Leeds City Council - Childrens and Families	188.60	185.20	(3.40)	97.60	96.20	1.40	208.00	215.00	(7.00)	305.60	311.20	(5.60)	(117.00)	(126.00)	(9.00)
Leeds Community Healthcare NHS Trust	94.70	98.20	3.50	64.60	64.70	(0.10)	30.10	33.50	(3.40)	94.70	98.20	(3.50)	0.00	0.00	0.00
Leeds Teaching Hospitals NHS Trust	785.78	818.15	32.37	464.55	469.45	(4.90)	321.23	348.67	(27.44)	785.78	818.12	(32.34)	0.00	0.03	0.03
Leeds & York Partnership NHS Foundation Trust	102.66	102.69	0.03	72.30	71.81	0.49	30.36	30.81	(0.45)	102.66	102.62	0.04	0.00	0.07	0.07
NHS Leeds CCG	690.59	688.46	(2.12)	7.69	7.55	0.14	680.77	683.03	(2.26)	690.58	690.58	(0.00)	0.00	(2.12)	(2.12)

Sign convention - (negative numbers) = ADVERSE variances

Narrative on YTD Position

Leeds City Council - Adult Social Care

At month 6 A&H reporting a balanced budget for 2021-22 financial year. There remain challenges / uncertainties going into Winter 2021-22 around impact of pressures on the NHS and Social Care workforce. Extension of the Infection Control Fund (ICF3 2021-22), £4.65m and the new Workforce Development & Recruitment Grant for £2.2m will provide financial support for the market. Demand as always continues to be a key risk, however labour capacity is restricting the ability to deliver all required social care.

Leeds City Council - Childrens and Families

At month 6 C&F a reporting a projected overspend of £8.99m. The key pressure relates to the budget for Children Looked After (CLA) and non-CLA placements, which is currently forecast to overspend by £6.485m. This is in part due to increased CLA placement numbers. The CLA service also has increased staffing costs which have resulted in a projected pressure of £735k. In addition to the CLA pressure the directorate is also projecting a net loss of £1.5m across its Nursery settings.

Leeds Community Healthcare NHS Trust

At the end of H1 the Trust is reporting breakeven. There are recurrent and non-recurrent Covid-19 related additional costs expected to continue throughout H2. In line with other H&SC organisations, the level of vacancies and the recruitment of staff is a significant challenge. Despite allocating resources to address waiting lists in 2021/22 progress in addressing these is slower than anticipated as staff are weary, there are less temporary staff available and both are continuing to support the Leeds vaccination programme.

Leeds and York Partnership NHS Foundation Trust

At month 6 the Trust reported an income and expenditure surplus of £67k against a planned balanced position.

Leeds Teaching Hospitals NHS Trust

In September the Trust reported income and expenditure to date of £818.1m resulting in a breakeven position. Income includes pay award funding, increased income to offset high cost drugs and devices spend and £15.4m ERF. Expenditure to date includes £22.6m of costs associated with COVID-19.

NHS Leeds CCG

The year-to-date position at the end of September shows an overspend of £2.1m for the H1 period, prior to anticipated reimbursements for covid out of envelope items such as the Hospital Discharge Programme (HDP). These anticipated allocations are subject to validation by NHSEI. Confirmed amounts will be awarded retrospectively on a quarterly basis. Quarter 1 reimbursement has been received in full after validation by NHSE. Retrospective allocations anticipated for quarter 2 are £2.1m, which would bring the year-to-date position to breakeven.

Leeds Health and Wellbeing Board

Report author: Ryan Rothery (Health Partnerships Team)

Report of: Tony Cooke (Chief Officer, Health Partnerships)

Report to: Leeds Health and Wellbeing Board

Date: 6 December 2021

Subject: Connecting the wider partnership work of the Leeds Health and Wellbeing Board

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

This report provides a summary of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). The report gives an overview of key pieces of work across the Leeds health and care system, including:

- Resilience and recovery plans for the Health and Care system in Leeds, with a particular focus on the impact of the pandemic on mental health

Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

1 Purpose of this report

1.1 The purpose of this report is to provide a public account of recent activity from workshops and wider system meetings, convened by the Leeds Health and Wellbeing Board (HWB). It contains an overview of key pieces of work directed by the HWB and led by partners across the Leeds health and care system.

2 Background information

2.1 Leeds Health and Wellbeing Board provides strategic leadership across the priorities of our Leeds Health and Wellbeing Strategy 2016-2021, which 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. We want Leeds to be the best city for health and wellbeing. A healthy and caring city for all ages, where people who are the poorest improve their health the fastest. This strategy is our blueprint for how we will achieve that.

2.2 National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change[1]. With good governance, the Leeds Health and Wellbeing Board can be a highly effective 'hub' and 'fulcrum' around which things happen.

2.3 This means that the HWB is rightly driving and influencing change outside of the 'hub' of public HWB meetings. In Leeds, there is a wealth and diversity of work that contributes to the delivery of the Strategy.

2.4 Given the role of HWBs as a 'fulcrum' across the partnership, this report provides an overview of key pieces of work of the Leeds health and care partnership, which has been progressed through HWB workshops and wider system events.

3 Main issues

3.1 The Health and Wellbeing Board convened a development session on October 7 2021. This session brought together a larger number of health and care partners (50+) to discuss the key impacts of the Covid pandemic on mental health across Leeds, focused around both existing and emerging needs. Attendees were asked to share their perspectives on the current Leeds picture as well as considering how to limit the impact of upcoming national policy changes which may have a direct impact on poverty levels in the city. The session supported the priority of the Leeds Health and Wellbeing Strategy to promote mental health and physical health equally.

3.2 In Leeds our health and care system leaders are committed to a city first and organisation second approach at all levels through the following principals of approach:

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

Leeds Health and Wellbeing Board: Development Session (7 October 2021)

3.3 At this session the following areas were discussed:

Mental Health as a Key City Priority

3.4 HWB were given the perspectives of city leaders from the NHS and Local Authority as to why we must continue to prioritise mental health to support with Leeds Covid recovery with key points including:

- The need to consider those population groups disproportionately impacted by the pandemic in all that we do
- Reduced access to mental health treatment and other coping mechanisms during the pandemic has created new, and exacerbated existing mental health issues
- A mental health crisis was already being experienced pre-pandemic with services struggling to meet demand, with a balance of preventative and self-management approaches required with targeted interventions for those most at risk
- Increased workforce burnout is evident with the impact of anxiety, depression, and PTSD with staff from culturally diverse communities being disproportionately affected, with the impact being felt on recruitment and retention

Leeds All Age Mental Health Strategy and Future in Mind Strategy

3.5 NHS and Local Authority colleagues provided an update on the ongoing work to improve peoples experience of mental health in Leeds through the All Age Mental Health Strategy and the Future in Mind Strategy (children and young people). The strategies ambitions are built around wanting to improve both service provision and peoples experience of mental health in Leeds.

Leading the Way: Our Role as a Health and Wellbeing Board

3.6 Led by Public Health colleagues members were asked to reflect on their role as a Health and Wellbeing Board in supporting peoples mental health in Leeds, with particular attention paid to the shrinking of health inequalities and pandemic recovery at a time of resource and capacity challenges.

Members were asked to reflect on 3 key questions:

- What can we do differently? The increase in mental health problems across the city will not be met by services alone

- How do we acknowledge that what people have faced is trauma? And how do we ensure this is recognised when supporting people?

- Going forward, how do we ensure that what we do doesn't increase inequalities?

Through the session a number of key points and themes were captured including:

- Over the next 2 years it is anticipated there will be an increase of 30% around support requirements

- Increased demand will not, and cannot, be met by services alone – we need to consider preventative approaches to reduce reliance on services during a time of challenging resource limitations

- With changes in wider context and national policy changes a widening of health inequalities is anticipated

    - Organisation leads need to ensure they are doing everything within their power to limit this widening and to consider the impact of poverty on mental health in Leeds

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 Health and Wellbeing Board has made it a city-wide expectation to involve people in the design and delivery of strategies and services. A key component of the development and delivery of each of the pieces of work for the HWB: Board to Board session is ensuring that consultation, engagement and hearing citizen voice is occurring.

4.2 Equality and diversity / cohesion and integration

4.2.1 Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

4.2.2 Any future changes in service provision arising from work will be subject to governance processes within organisations to support equality and diversity.

4.3 Resources and value for money

4.3.1 Each of the pieces of work highlighted in this report evidences how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long term commitment to financial sustainability.

4.4 Legal Implications, access to information and call In

4.4.1 There are no legal, access to information or call in implications arising from this report.

4.5 Risk management

4.5.1 Risks relating to each piece of work highlighted is managed by relevant organisations and boards/groups as part of their risk management procedures.

5 Conclusions

5.1 In Leeds, there is a wealth and diversity of work and initiatives that contribute to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021 which is a challenge to capture through public HWB sessions alone. This report provides an overview of key pieces of work of the Leeds health and care system, which has been progressed through HWB workshops and events with members.

5.2 Each piece of work highlights the progress being made in the system to deliver against some of our priorities and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

6 Recommendations

The Health and Wellbeing Board is asked to:

- Note the contents of the report.

7 Background documents

7.1 None.

THIS PAGE IS LEFT INTENTIONALLY BLANK

How does this help reduce health inequalities in Leeds?
Each of the pieces of work highlighted in this report, through the strategic direction of the Health and Wellbeing Board, is aligned to priorities of our Leeds Health and Wellbeing Strategy 2016-2021 and our vision of Leeds being a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

How does this help create a high quality health and care system?
National guidance states that: to make a real difference for the people they serve, Health and Wellbeing Boards need to be agents of change. The Leeds Health and Wellbeing Board is rightly driving and influencing change outside of the 'hub' of public HWB meetings to ensure that the wealth and diversity of work in Leeds contributes to the delivery of the Strategy. The Board is clear in its leadership role in the city and the system, with clear oversight of issues for the health and care system.

How does this help to have a financially sustainable health and care system?
Each of the pieces of work highlighted in this report evidences how the Leeds health and care system are working collectively with the aim of spending the Leeds £ wisely under the strategic leadership of the HWB. The volume of partnership working is testament to the approach taken – sharing or integrating resources, focusing on outcomes and seeking value for money as part of its long term commitment to financial sustainability.

Future challenges or opportunities
In the wealth and diversity of work there is an ongoing opportunity and challenge to ensure that the Board, through its strategic leadership role, contributes to the delivery of the Strategy in a coordinated and joined up way that hears the voices of our citizens and workforce.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	X
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	X
A strong economy with quality, local jobs	X
Get more people, more physically active, more often	X
Maximise the benefits of information and technology	X
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	X
The best care, in the right place, at the right time	X