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

Report to: Inner South Community Committee

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Date: 12th June 2019 **To note**

Leeds Health and Care Plan, Continuing the Conversation

Purpose of report

1. Provide the Community Committee with an update on the progress made in actions contained within the Leeds Health and Care Plan following the previous engagement with the Committees in autumn 2017.
2. Provide a summary of progress made in implementing the emerging Local Care Partnerships (LCPs).
3. To outline the rationale for refreshing the Leeds Plan and progress made to date.
4. To provide Community Committees with the information required to appoint elected members to LCPs

1 What is the Leeds Health and Care Plan?

1.1 The Leeds Health and Care Plan (the plan) is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. The Leeds Health and Care Plan is guided by the vision that in 2021 Leeds will be a healthy and caring City for all ages where people who are the poorest improve their health the fastest. Implementation of the plan should take the Leeds Health and Care system some way towards achieving this vision.

1.2 It is also our 'place based plan for the West Yorkshire and Harrogate Integrated Care System (ICS).

1.3 Integrated Care System (ICS) are partnerships of health and care organisations (including the Ambulance Service, Community Healthcare providers, Clinical Commissioning Groups, Healthwatches, Hospital Trusts, Local Authorities, Mental Health Trusts and the Voluntary and Community Sector) that work collectively to plan health and care services on a larger footprint. West Yorkshire and Harrogate Health and Care Partnership is an ICS in development – meaning it has some limited responsibilities for system oversight, but no devolved responsibilities or budgets.

1.4 The NHS Five Year Forward View in 2016, described health and care planning across three levels. The approach starts with where people live – their neighbourhood or locality, in our context the Local Care Partnerships (LCPs). Secondly the approach uses the power of 'place', in our context Leeds, where Health and Care services can collaborate most effectively with many of the wider determinants of health such as housing, employment, environment and skills. It then recognises certain key service improvements may happen best working across a wider geography. The West Yorkshire and Harrogate Integrated Care System (ICS) supports the importance and primacy of the Leeds Health and Care Plan as one of six 'place' based plans within the overall geography.

1.5 The Leeds Health and Care Plan has been developed through extensive political engagement. An initial round of discussions in 2017, with ten community committees, involved presenting the case for change in our health and care system. These were led by local GPs and system leaders and presented local data on needs. The local conversations generated significant support and comment for the approach, which was captured and used to amend and refine the Leeds Health and Care Plan.

1.6 There has also been and continues to be significant engagement with the public on individual components of the Leeds Plan. In 2018/19 this has included consultation on:

- Ways of working better locally - A deliberative event was held in April 2018 with the public, patients and carers in Leeds about the new ways of local working to support us in developing our plans and priorities
- The support that young parents need – reviewing maternity information for young parents (under 25) and information used will improve the way this group are referred into maternity services
- People living with Frailty - understanding what matters to people living with frailty, those at the end of their life and their carers to support development of a tool that measures outcomes from a patient perspective ; and
- Social Prescribing - understanding peoples experiences of Social Prescribing to support the development of a new service that meets peoples' needs and preferences.

1.7 The Leeds Health and Care Plan works across three dimensions. The first captures principles, qualities and behaviours that have wide implications in how we all work with people. The second has been to work across four programmes to accelerate partnership working for specified projects. The third dimension has drawn together our collective resources that enable transformation (workforce, finance, digital, innovation, estates).

Leeds Health and Care Plan *By 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest*				
A plan that will improve health and wellbeing for all ages and for all of Leeds which will…				
Protect the vulnerable and reduce inequalities		Improve quality and reduce inconsistency		Build a sustainable system within the reduced resources available
Our community health and care service providers, GPs, local authority, hospitals and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that…				
Have citizens at the centre of all decisions and change the conversation around health and care				
Build on the strengths in ourselves, our families, carers and our community; working with people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong				
Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens				
Use neighbourhoods as a starting point to further integrate our health, social care and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis				
Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do				
Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire				
What this means for me…	**Prevention "Living a healthy life to keep myself well"**	**Self Management and Proactive Care "Health and care services working with me in my community"**	**Optimising Secondary Care "Go to a hospital only when I need to"**	**Urgent Care and Rapid Response "I get rapid help when needed to allow me to return to managing my own health in a planned way"**

1.8 The four programmes of projects to accelerate partnership working referred to above are; prevention at scale; self-management and proactive care; optimising secondary care; and unplanned care and rapid response.

1.9 Achievements of the Leeds Health and Care Plan can be found in section 4 aof this report and in appendix 4. However, to further build on this success and in recognition of the need to evolve and adapt to changes in the system, the strategic context for committing to a forward look and refresh of the Plan is compelling. Further detail on this is provided in section 5 of this report.

2 What are Local Care Partnerships?

2.1 Local Care Partnerships (LCPs) form the basis of Leeds' vision of locally integrated health, wellbeing and care based in communities. They will use a "bottom up" approach to improving health, wellbeing and care with a focus on priorities such as a better response to people living with frailty. LCPs are based on 18 geographies which aim to mirror natural communities, GP practice patient lists and existing relationships between GPs. Please see appendix 1 for the map of LCP areas.

2.2 As can be seen from this map, the LCPs that predominantly cover this Community Committee are Middleton and Beeston.

2.3 Each LCP will use a multi-agency approach working with staff and local resources including those which impact on the wider determinants of health, such as housing or employment. LCPs are formative. They are aligned to existing 13 Neighbourhood Teams and emerging Primary Care Networks (PCNs) but will take time and resources to support their development and therefore will take a number of years to achieve their full potential.

2.4 Resource requirements for developing LCPs are being addressed by putting additional support in place. The need to develop neighbourhood models has been recognised within the Integrated Care System arrangements for West Yorkshire and Harrogate, and this has resulted in allocated funding to Leeds to progress its requirements. To date this has resulted in recruiting a Head of LCP Development and supporting team and includes a specific role to support voluntary sector inclusion and participation in LCPs.

2.5 In the recent ward member conversations there was overwhelming support for the LCP approach as a route to better outcomes through integrated working.

2.6 Reflecting the progress Leeds is making in establishing LCPs, developing outcomes for people living with frailty as a whole population and establishing linked data, Leeds was selected as one of four 'leading edge' sites to participate in a national 20 week Population Health Management programme. Having a population outcomes framework has brought together providers working across organizational boundaries to design approaches and achieve outcomes that matter most to people. 4 LCPs – Pudsey, Woodsely, Seacroft and Garforth have designed personalised interventions to support people living with frailty. 7 further LCPs (with an emphasis on the more deprived areas of Leeds) will start this work in September. Further information on the population health management approach can be found in appendix 2.

2.7 Through the NHS Long Term Plan, additional resources will be invested in a local approach through an initiative known nationally as Primary Care Networks (PCNs). PCNs will support better contracting, additional innovation funding and develop clearer roles to support our Leeds LCP approach.

2.8 LCPs will benefit from this and will support PCN development through bringing together leaders from statutory health and care services with third sector, housing, employment, planners, elected members and local people to deliver the ambition of the Leeds Health and Wellbeing Strategy.

3 Progress made in the last year

Engagement / Big Leeds Chat

3.1 A specific commitment made to both the Leeds Health and Wellbeing Board and the Community Committees in 2017 was 'having citizens at the centre of all decisions and change the conversation around health and care'. This is one of the guiding principles of the Leeds Health and Care plan.

3.2 As part of this commitment The Big Leeds Chat, a new 'one partnership, one city' approach to engagement with citizens, took place on 11 October 2018 in Kirkgate Market. It is planned to be an annual event and the next Big Leeds Chat will be taking place on 7th November 2019.

3.3 The listening event focused on three questions: what do you love about Leeds, what do you do to keep yourself healthy and lastly what can we do to make Leeds the best city for health and wellbeing? This was followed, where appropriate, by detailed conversations between people and decision makers on the topics that mattered to people related to health and care in the city.

3.4 The principles of the Big Leeds Chat approach were:

Principle	**Action**
Go to where people are	The event took place at Leeds Kirkgate Market which has a footfall of over of 25,000 on a Thursday and brings together people from many different communities, geographic, socioeconomic and communities of interest from all over Leeds.

One health and care team	We asked people to imagine that we were working for a coordinated health and care system and therefore there was a no jargon, no lanyard approach and everyone wore yellow Big Leeds Chat t-shirts.
Senior decision makers	There was significant attendance from senior decision makers and policy makers. This meant that people could speak directly with people that make things happen as well as giving real insight to decision makers about their everyday lives and experiences.

3.5 Key themes raised during this event can be found in Appendix 3. Themes cover both health related issues and wider determinants of health, such as education and housing.

4 Progress made though the Leeds Plan

4.1 To date, through the strategic leadership of the Leeds Health and Wellbeing Strategy, the Leeds Health and Care Plan has driven a number of successes that are to be celebrated. Some examples of where we are starting to see a difference locally include:

- There were 9,291 Collaborative Care Support Planning (CCSP) appointments held locally between 1st April and 31st December 2018. CCSP facilitates a change in people's annual review for long term conditions. It enables the person to be more prepared for the consultation by ensuring they receive their results and relevant information in advance of the review, and therefore be a true partner in their care.
- 576 referrals to the National Diabetes Prevention Programme were made in the area between April 18 and March 19. The programme aims to help people reduce their risk of developing Type 2 diabetes, by offering them a referral to an intensive lifestyle intervention programme.
- 438 GP referrals were made to the One You Leeds service between April 2018 and March 2019. One You Leeds was designed to support Leeds residents to start and maintain a healthy lifestyle. It has a key aim to support the ethos of 'improving the health of the poorest the fastest'.
- The cancer programme, has the objective to achieve the best in cancer care for the people of Leeds. The cancer team are working with Middleton and Beeston practices as part of the Phase 1 Yorkshire Cancer Research funded project to embed Screening and Awareness Co-ordinators within the LCP. The focus is on increasing screening uptake across all 3 national programmes and raising awareness of risk factors/ signs and symptoms of cancer to drive prevention and earlier detection of cancer in the area. Locally in Middleton, there has been a decreasing trend in all 3 national screening programmes. In Beeston, there appears to be a low prevalence of cancer in the area, however there is also a low percentage of cancers diagnosed through the 2 week wait referrals. The area also has higher did not attend rates to 2 week wait referral appointments and below national average on all national screening programmes, in particular bowel uptake is low. As a result, a number of practices in this area have some funded time through the CCG for a Practice Based Bowel Screening Champion.
- The St Georges Centre in Middleton, was formally designated as an Urgent Treatment Centre in December 2018 by NHS England.
- Breathe Easy groups have been established in Middleton and Beeston. The groups are part of an integrated network of respiratory peer support groups in Leeds which will result in higher quality and more consistency in terms of how patients with chronic obstructive pulmonary disease (COPD) manage their condition.

We are not yet able to break down the local impact of as many city initiatives as we would like to, however appendix 4 details further successes which will benefit residents in the Community Committee area.

4.2 The broader successes include:

- A first plan for Leeds spanning the health and care system developed through significant co-production;
- An organic plan shaped by wide range of partners;
- Elected Member engagement as central to the changes;
- Developing a strong identity and thinking of Leeds as a place;
- Simple yet effective approach with better consistency in language and definition;
- Understanding that we have to operate within our means and refocus existing resources to develop and implement change; and
- A governance framework that is being led by connections, relationships, trust and a collective ambition rather than processes and strict governance.
- A recognised cross cutting golden thread of the importance of 'working with' people

4.3 In terms of the overall practical impact of the plan, as a system, we are pleased to say that:

- Data released by Public Health England shows that smoking rates in Leeds are continuing to fall and are now at the lowest in West Yorkshire.
- The work of the Best Start programme and Children and Young People's Plan has led to Leeds bucking the trend in child obesity rates among four and five year olds. Leeds is the only English City to achieve this. The drop in obesity has been seem primarily among the most disadvantaged areas in the city. In general obesity levels fell from 9.4% to 8.8% in reception age children with levels falling from 11.5% to 10.5% in the most deprived areas.
- This winter not a single patient was cared for in a non-designated area - this is where someone is being treated in a space that's not dedicated for patient care.
- We also made significant strides this winter in reducing delayed transfers of care so that patients aren't staying longer than they need to within a hospital-based setting. This fits in with our 'Home First' ethos which means that people will be supported to remain or return quickly to their own beds, and their own home (including a care home if that is their usual place of residence) wherever possible.

5 Next Steps

5.1 The Leeds Health and Care Plan is making a significant contribution towards achieving our Health and Wellbeing Strategy. To build on this success and in recognition of the need to evolve to adapt to changes in Leeds, the strategic context for committing to a forward look and refresh of the Plan is compelling for the following reasons:

- **Progress achieved -** Aspects of the current Leeds Plan have been completed therefore some actions may no longer need to be included, or alternatively through delivery have become embedded as business as usual.
- **Local context -** The emerging headlines from our Joint Strategic Assessment (JSA) which looks at the current and future health and care needs of a population, highlights the need for a continuing and expanded focus on the wider determinants of health and challenge to reduce health inequalities in Leeds. There are significant emergent changes in need, particularly in our deprived communities that require support.
- **National and regional context -** The NHS Long Term Plan, published in January 2019 states that all regional Integrated Care Systems (ICS), such the West Yorkshire and Harrogate Health and Care Partnership (WY&H Partnership) that Leeds is part of, will have a central role going forward. Since the majority of the work of the WY&H Partnership will be in the health and care plans from each place (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds, Wakefield) the refreshed Leeds Plan will be a key component of this.

5.2 The previous conversations at Community Committees in 2017 significantly influenced and directed the Leeds Plan. Similarly, we invite to board to consider the local implications and comment on local priorities to shape the future of the Leeds Health and Care Plan.

6 Appointing elected members to Local Care Partnerships

6.1 We have had significant engagement with elected members to date on Local Care Partnerships through a range of routes including:

- Discussions at Community Committees in 2017 and 2018
- Ward level health and care conversations with elected members
- Citywide Health, Wellbeing and Adults Community Committee Champions meeting

Through these engagements elected members fed back the following:

- Overwhelming support for the Local Care Partnerships approach as a route to better outcomes through integrated working by not only health and care partners, but those that impact on the wider determinants of health and wellbeing (e.g. Housing).
- Elected members have valuable knowledge and intelligence of the area they represent and the importance of a democratic link between Local Care Partnerships and Community Committees.
- There should be elected member representation on Local Care Partnerships aligned with Community Committees, particularly through the role of Health, Wellbeing and Adults Community Committee Champions to promote local conversations and closer working.

6.2 In order to deliver on the feedback we have received, elected member appointments to LCPs have been delegated to Community Committees by Member Management Committee in a similar way to Housing Advisory Panels/Clusters. As a result, work has occurred to map LCPs to Community Committees (see Appendix 1 – LCP 2019 footprints and Community Committee boundaries) and a detailed population analysis of local residents (see Appendix 5).

Based on this analysis, it is recommended that Inner South Community Committee:

- Appoints 1 elected members to Middleton LCP and Beeston LCP based on the suggested alignment outlined in the table below (or more subject to its discretion).

Community Committee	Suggested number of LCP appointments	Names of LCP appointed to
Inner North West	2	1 Holt Park LCP & Woodsley LCP *(both LCPs meet jointly)* 1 Leeds Student Medical Practice
Inner East	2	1 Seacroft LCP *(meetings occur jointly with Crossgates LCP)* 1 Harehills LCP & Burmantofts and Richmond Hill LCP *(meets jointly as HATCH LCP which includes Chapeltown LCP)*
Outer North West	1	1 Aire Valley LCP & Otley LCP *(Both LCPs meet jointly)*
Outer South	2	1 Garforth/Kippax/Rothwell LCP 1 Morley LCP
Inner South	1	1 Middleton LCP & Beeston LCP *(both LCPs meet jointly)*
Outer East	2	1 Garforth/Kippax/Rothwell LCP 1 Crossgates *(meetings occur jointly with Seacroft LCP)*
Inner North East	2	1 Central LCP (includes Meanwood and Moortown) 1 Chapeltown LCP *(meets jointly as HATCH LCP which includes Harehills LCP & Burmantofts and Richmond Hill LCP)*
Inner West	1	1 Armley LCP
Outer West	1	1 Pudsey LCP (includes Bramley)
Outer North East	1	1 Wetherby LCP

- Appoints the Health, Wellbeing and Adults Community Committee Champion to LCPs as one of its appointments (subject to its discretion).

7 Role of elected members on Local Care Partnerships

7.1 Elected members' roles in LCPs will develop as LCPs mature, but will include helping to shape and influence local health and care services to address local needs in addition to achieving citywide priorities. It is envisaged that elected members may use their local knowledge and wider links and influence to impact the wider determinants of health. It is expected that:

- Frequency of formal partnership meetings will be at least once a quarter. Each LCP is unique and may meet more frequently with elected members having the opportunity to be more actively involved in shaping them as they develop.
- The appointed elected member(s) continue to strengthen the relationship between Community Committees and Local Care Partnerships as part of an ongoing broader conversation about health and wellbeing within each locality.

After appointment support will be given to elected members to create initial engagement with LCP's, this will begin with, and learn from, areas where LCP working is most mature.

Recommendations

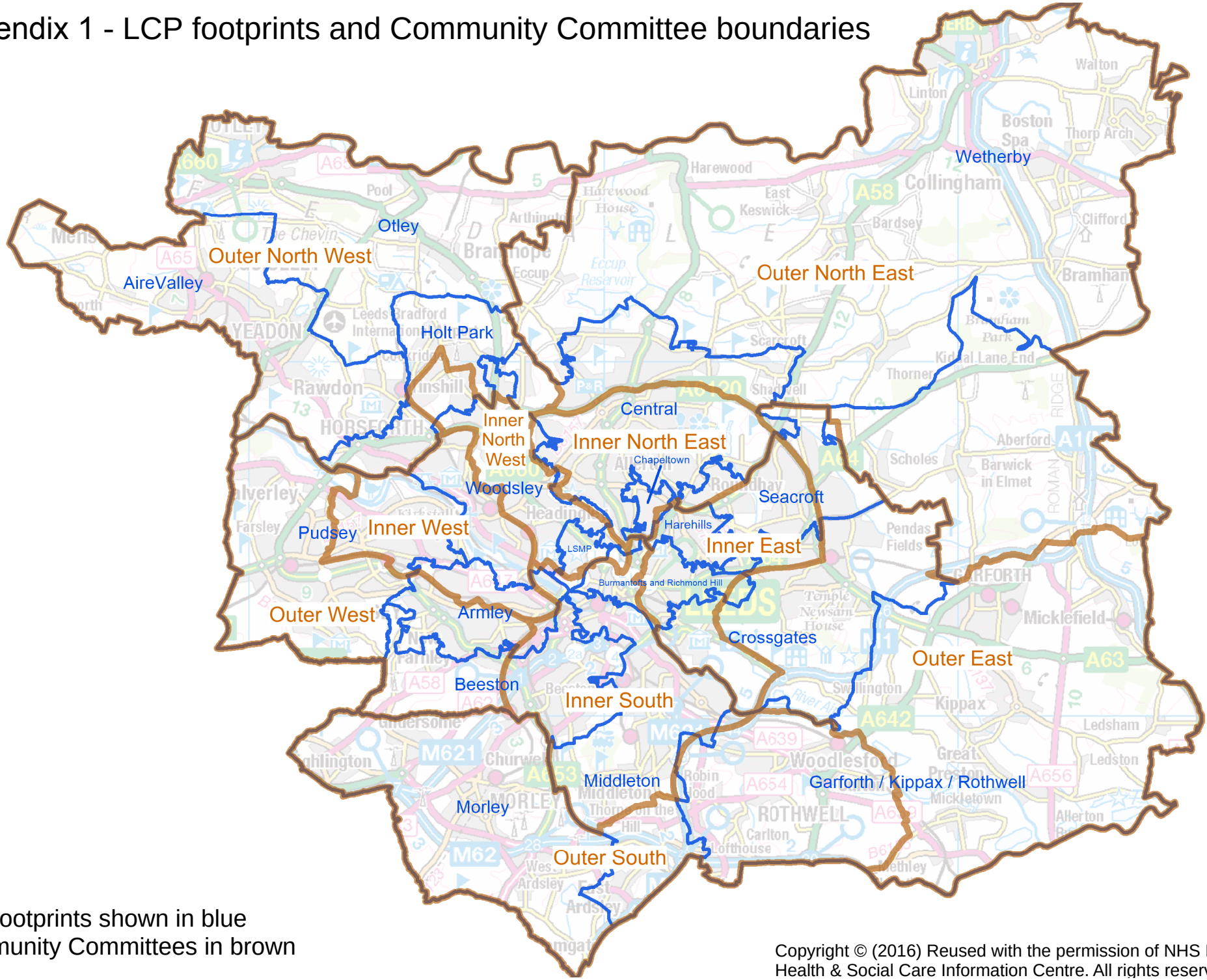
The Community Committee is asked to:

a) Note the overall progress in delivery of the Leeds Health and Care Plan;

b) Discuss and agree the approach to elected member appointment on LCPs

c) Consider the local priorities to inform the refresh of the Leeds Health and Care Plan

Appendix 1 - LCP footprints and Community Committee boundaries



LCP footprints shown in blue
Community Committees in brown

Appendix 2: What is Population Health Manageme

Leeds Health and Wellbeing Strategy

Leeds wants to be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'. We believe that using a Population Health Management approach will be a key mechanism to enable us to achieve this commitment.

What is Population Health Management?

Population Health Management (PHM) is founded on a collective understanding, across organisations, of the needs and behaviours of the defined population they are responsible for. It uses data to understand where the greatest opportunities to improve health outcomes, value and patient experience can be made; and then using available resources to plan, design and deliver care solutions to achieve better outcomes for the defined population. PHM is a data driven approach which focuses resources on preventative and proactive care.

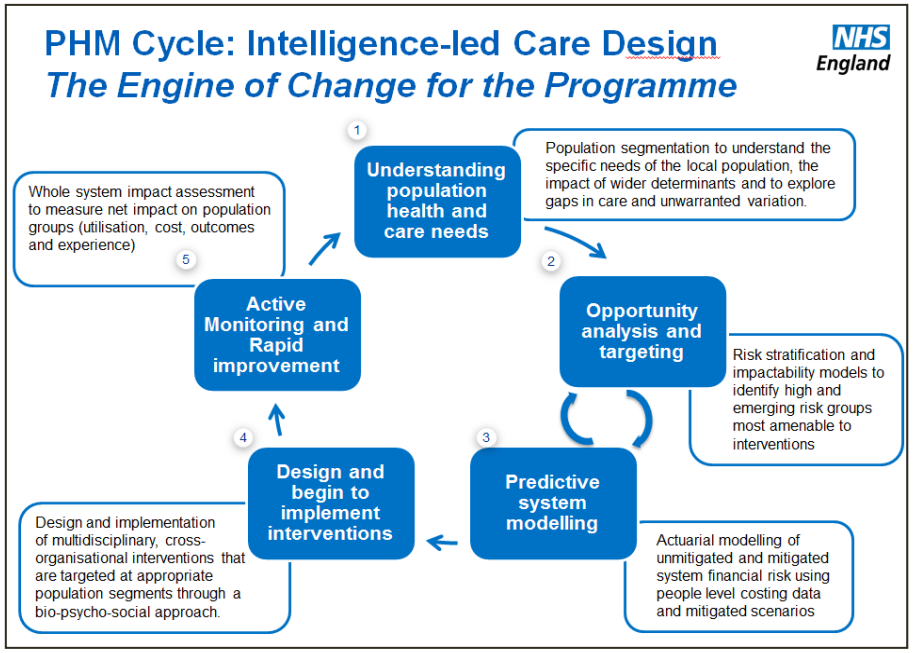
What is happening in Leeds?

Reflecting the significant progress Leeds has made in establishing Local Care Partnerships, developing outcomes for people living with frailty and establishing linked data, Leeds has been selected as one of four 'leading edge' sites to participate in a national 20 week Population Health Management programme which will run from January to May 2019.

The programme is being delivered by NHS England and their partner Optum Alliance who are providing dedicated expertise. The programme will focus on progressing a PHM approach to improve outcomes for people living with frailty.

What are the aims of the PHM development programme in Leeds?

1. Changes in care delivery to achieve demonstrably better outcomes and experience for people:
2. Advancing the system's PHM infrastructure and enabling future use of PHM cycle:



Programme Structure

Programme leadership team (with support and guidance from System Executive team in PEG)

- **Tim Ryley**, PEG Executive Sponsor (Chief Executive, NHS Leeds CCG)
- **Dr Chris Mills**, Clinical Lead (GP and Chair of Leeds GP Confederation)
- **Gina Davy**, Co-Workstream Lead (Head of Programme Delivery, System Integration, NHS Leeds CCG)
- **Lucy Jackson**, Co-Workstream Lead (Consultant in PH/Chief Officer Adults and Health, Leeds City Council)
- **Frank Wood**, Analytics Lead (Chief Analyst – Portfolio Lead for Public Health and Health Intelligence, Health and Care Hub, Leeds City Council / NHS Leeds CCG)
- **Caroline Baria**, Adult Social Care (Deputy Director, Integrated Commissioning, Adults & Health Directorate, Leeds City Council)
- **Joanne France**, Project Manager (System Integration, NHS Leeds CCG)

PHM Executive: *Clinical Strategy Group for Frailty*	Design to Action Team: *4 Local Care Partnerships*	Business Intelligence Team: *System BI & Finance Leads*
Activities include: • Practical support from Optum clinical and population health team on care redesign	Activities include: • Assessment & implementation of interventions to change care delivery for local populations	Activities include: • Practical support from Optum actuaries and population health analytics SMEs
Outputs include: • Identification of local opportunities • Development of targeted interventions and implementation • Construction of measures to test and evaluate interventions' success • Learning and sharing best practice	Outputs include: • Team of system change agents work to support delivery of PHM interventions on the front line • Analyse local data and evaluate opportunities for intervention • Design and implement local initiatives to change frontline care delivery in Leeds	Outputs include: • Localised population health insight report • Case for change for identified opportunities • Balanced outcomes framework • System model

Selecting the four Local Care Partnerships

The four LCPs participating in the PHM programme were identified by assessing:

- Maturity of relationships
- Frailty identified as a priority
- Interest and willingness to patriciate in the programme

The final list of four LCPs were then selected on the basis of:

- Deprivation of LCP area
- Prevalence of frailty

The four LCPs participating in the initial 20 weeks pilot are:

1. Pudsey
2. Woodsley
3. Seacroft
4. Garforth, Kippax & Rothwell

Appendix 3 – Big Leeds Chat Key Themes

Theme	Key Points
Diet	People told us that their diet is an important part of keeping healthy. Almost a third of the people we spoke to told us that they keep themselves healthy by eating well. For some people this was about cooking fresh food at home, for others it was about eating less and reducing the amount of alcohol they drink.
Exercise	Keeping fit and active was identified by many people as important. Walking, running and gardening are seen by many people as an easy and cheap way to keep fit and healthy. People also told us that activities such as going to the gym, cycling and yoga help them to keep themselves healthy.
No time for self-care	Some people also told us that a lack of time and motivation makes it difficult to take part in healthy activities. Poor health was another reason why people find it harder to get involved in healthy activities.
Cost	45 people told us that leisure facilities are too expensive and that free or affordable activities would encourage more people to stay fit and active. Some people also said that it was too expensive to buy healthy food and that public transport was not affordable.
Transport	21 people told us that they would like to see public transport improved by providing better bus routes, cheaper fares and a more reliable service. Many people also raised concerns about congestion in the city and suggested that less cars in the city centre and more pedestrian areas would make Leeds a better city for health and wellbeing.
Information	Some people told us that information about healthy activities in the city should be easier to find. People also want more information about how to self-care and stay healthy.
Environment	People told us that the environment they lived in was important to them and that they want more green spaces nearby. Some people raised concerns about smoking and asked for more smoke free areas in Leeds.
Healthcare	Many people are happy with the health services they receive in Leeds, but some people are unhappy with access to specialist services and waiting times (especially for GP surgery appointments). Many people told us that they want better mental health services in the city with improved access to counselling and shorter waiting lists.

Education	Some people told us that they would like to see local schools being more involved in promoting health and wellbeing with young people and parents.
Employment	Some people told us that they feel that there are not enough jobs in Leeds and that more should be done to create employment opportunities.
Housing	Some people told us that they want better housing in Leeds, especially for deprived communities and the homeless.

Appendix 4 – Leeds Plan Successes

Prevention at scale – "Living a healthy life to keep myself well"

Progress is being made to reduce the future burdens on the NHS and social care resources. Focus includes:

- Ensuring people who live healthy lives continue to do so
- Increasing the number of people who are prompted and supported to change unhealthy behaviours to enable them to live healthy lives;
- Ensuring our future generations are born healthy and enjoy healthy living as the norm

Recent successes under this programme include:

Project and Description	Successes
Better Together The programme focusses on the issues that lead to poor health, such as social isolation, and use a community development approach to work with individuals, groups and communities to help them improve their situation and live longer, healthier lives.	Outreach work has engaged over 18,000 people from the 10% most deprived communities into community groups and programmes to improve general health and wellbeing.
'One You Leeds' (OYL) OYL is designed to support Leeds residents to start and maintain a healthy lifestyle. It has a key aim to support the ethos of 'improving the health of the poorest the fastest'. There is a specific aim around increasing access by specific target populations (eg. people living in deprived Leeds, people at risk of long term conditions, pregnant women and emerging migrant populations).	OYL continues to achieve high levels of referrals into the service. In the Inner South Community Community area there were 438 GP referrals to the service One You Leeds between April 2018 and March 2019.
Alcohol Programme This programme aims to continue to reduce harm from alcohol through: • promoting safe alcohol consumption as the norm • reducing access to alcohol by young people and providing; and • promoting alternative routes to behaviour change for those people who would prefer to self-help.	There has been a significant amount of activity over the last year aimed at alcohol awareness, including; Alcohol awareness week held from 19 to 25 November which saw significant alcohol related health promotion. The 'No Regrets' campaign, an online responsible drinking campaign aimed at 18-25 year olds. Forward Leeds holding a series of events across the city, where people were able to make positive pledges to change their drinking behaviour.

	There has also been a focus on secondary prevention for people who may be attending health services for a condition and present an opportunity to discuss smoking and alcohol use. For example, the Nursing Specialist Assessment 'e-form' is now live on all inpatient wards throughout Leeds Teaching Hospitals NHS Trust (LTHT). This means alcohol and tobacco screening is now being undertaken as part of every inpatient's admission into the hospital as they come onto the wards.
Tobacco Programme This programme aims to continue to reduce the harm from tobacco through promoting smoke free as the norm, reducing access to tobacco by young people and providing and promoting alternative routes to behaviour change for those people who would prefer to self-help.	Smoking prevalence across the city is now at an all-time low of 16.7%. Progress continues to be made towards the aim to create a smoke free generation, with over 35,000 less smokers in Leeds than there were in 2011. Data released by Public Health England shows that smoking rates in Leeds are continuing to fall and are now at the lowest in West Yorkshire.
Best Start The programme has a key aim to give every child the best start in life, specifically the crucial period from conception to the age of 2.	Food and activity for a Healthy Pregnancy sessions have been made available for pregnant women with a BMI over 25 (and their partners). The sessions use the HENRY strengths based approach – building on participant's current knowledge and begins with an activity looking at what they think a healthy pregnancy looks like. The work of the Best Start programme has led to Leeds being the first city in the UK to report a drop in childhood obesity. There is also a lot of ongoing work with the maternity voices group, ongoing engagement with young people and their families. There has been a focus on mental health, and support for breastfeeding.

Self-Management and Proactive Care - “Health and care services working with me in my community”

This programme vision is that

In 5 years time people will be able to confidently manage their own health and wellbeing and services will be delivered in a way that identifies and addresses need earlier. Self-Management and Proactive Care will be embedded into every relevant pathway across Leeds?’

We are achieving this by:

- Put in place accessible, appropriate opportunities for support so that people have the knowledge, skills and confidence to live well with their long term condition
- Equip staff with the knowledge, skills and confidence to support someone with managing their long term condition
- Ensure the systems and process support a person centred collaborative approach to long term condition management
- Improved Early Identification of symptoms and conditions
- Improved Management of people with diseases
- Improved support for people at the end of their life

Recent successes under this programme include:

Project and Description	Success
Better conversations Better conversations is a culture change programme moving the conversation between worker and citizen from a paternalistic dynamic where the worker is viewed as the ‘expert’ and has a role to ‘fix’ the citizen, towards an equal partnership where the worker looks to enable the citizen	To date 48 skills days have been developed overall, with over 700 attendees from 52 different health and care organisations across the city including both the statutory and third sector. Specific skills sessions have taken place for Seacroft and Crossgates LCPs and a session will be taking place with Pudsey LCP in June with a view to potentially rolling sessions out across all LCPs to ensure that focused localities develop skills together at the same time. 89% of attendees agreed or strongly agreed that they will use the skills practiced in their role.
The Diabetes Structured Education Programme To improve uptake for Type 2 Diabetes education courses with an emphasis on targeted groups (men over 40 and BME) with the overall outcome that people feel well supported and confident to manage their condition.	In the last quarter of 2018 there have been 347 referrals into the Diabetes Structured Education Programme. Diabetes education sessions have increased from 33 to 125 per annum.

Self-Management support is now part of the ICS Universal Personalised care plan programme as detailed by NHS England (NHSE).	The percentage of people reporting an improved confidence to manage their condition after the course is sustained at 100%. Representation in those attending of the targeted groups for the programme remain strong – men over 40 years (52%), proportion of attendees from deprived areas (62%) and people from BAME groups (51%).
National Diabetes Prevention Programme (NNDP) The programme aims to help people reduce their risk of developing Type 2 diabetes, by offering them a referral to an intensive lifestyle intervention programme. The intervention consists of improved diet, weight loss and increased physical activity. Self-Management support is now part of the ICS Universal Personalised care plan as detailed by NHSE	Between April 1 2018 and March 31 2019 5,542 people have been referred for the National Diabetes Prevention Programme (NNDP). In the Inner South Community Committee area, 576 referrals to the NDPP Programme were made between April 18 and March 19
Breathe Easy The project aims to develop an integrated network of respiratory peer support groups in Leeds which will result in higher quality and more consistency in terms of how patients with COPD manage their condition.	The 10 Breathe Easy groups in Leeds are in a position of sustainability. The groups are located in Bramley, Middleton, Gipton, Hunslet, Yeadon, Beeston, Allerton Bywater, Harehills, Richmond Hill and Osmondthorpe. All groups are now operating from low/no cost venues and the numbers attending are growing. This project has led to a wider programme of developing peer support networks with people with long term conditions.
Collaborative Care Support Planning (CCSP) CCSP facilitates a change in people's annual review for long term conditions. It enables the person to be more prepared for the consultation by ensuring they receive their results and relevant information in advance of the review, and therefore be a true partner in their care. The results forms a collaborative discussion between professional and person, focusing on "what is important to the person" enabling person	There have been 85,859 CCSP Annual reviews performed in Leeds between April 1st 2018 and March 31st 2019.This programme is part of the ICS Universal Personalised care plan programme as detailed by NHSE. Leeds has been recognised by the ICS and NHSE as meeting the quality markers for personalised care planning.

centered goals to be agreed to support people to self-manage their condition.	In the Inner South Community Committee area, there were 9,291 CCSP appointments held between 1st April and 31st December 2018.
Social Prescribing Social Prescribing offers activity, social and cultural interventions in communities as an alternative to or adjunct to medical interventions.	Social Prescribing is also now part of the ICS Universal Personalised care plan programme as detailed by NHSE There has been 3749 referrals to the Social Prescribing service. The city is on track to meet the target of 5,000 referrals for the year. Following reprocurement by the CCG there will now be one provider (a consortia) covering the whole of the city, and ensuring that all LCPs have social prescribers.
Virtual Respiratory Ward Leeds Community Healthcare NHS Trust's virtual respiratory ward was expanded to cover Armley to help patients with long-standing respiratory conditions.	The virtual respiratory ward is designed to help those with Chronic Obstructive Respiratory Disease (COPD) exacerbations avoid being admitted to hospital and support earlier discharges for those that have been admitted. COPD can be caused by a number of things including smoking and genetics.
Frailty Unit A multi-disciplinary team work on the unit providing medical and holistic care for patients over the age of 80, or from 65 if they have particular frailty needs. Emergency departments can be really busy and noisy with lots going on. This can be really difficult for older patients while they are waiting, particularly if they are frail and may have dementia. The Frailty Unit is set away from the main emergency department, so it's a lot quieter and a much better environment for our older patients to be while they're being assessed.	The latest available figures (November 2018) show that the frailty unit at St James's Hospital has prevented 951 admissions in nine months, around 1902 bed days.

Optimising Secondary Care - “Go to a hospital only when I need to”

Progress is being made with activities with focus to:

- Improve the ways in which we test for cancer, provide treatment and offer support to people after they have had a cancer diagnosis.
- Ensure people will not stay in hospital longer than they need
- Reduce the visits people need to take to hospital before and after treatment
- Have a system that supports people with mental illness requiring secondary care interventions in the most appropriate setting.
- Ensure people will get the medicines that are the best value for them and the city

Recent successes under this programme include:

Project and Description	Successes
Cancer Programme The objective of the programme is to achieve the best in cancer care for the people of Leeds. The programme is centred around four areas of focus: • Prevention awareness and screening • Early diagnosis • Living with and beyond cancer • High quality modern services	713 additional people have completed a bowel screening test since April 2018 after being contacted by practice champions. The Accelerate Coordinate Evaluate (ACE) pilot pathway is for patients with non-specific but concerning symptoms has now been mainstreamed and the 1000th patient has just recently been referred on this pathway. Early evaluation indicates ACE provides faster diagnosis and clarity to patients and physicians, improves diagnostic findings of other significant but non-cancer conditions and as equally or more cost effective than previous approaches. The cancer team are working with Middleton and Beeston practices as part of the Phase 1 Yorkshire Cancer Research funded project to embed Screening and Awareness Co-ordinators within the LCP. The focus is on increasing screening uptake across all 3 national programmes and raising awareness of risk factors/ signs and symptoms of cancer to drive prevention and earlier detection of cancer in the area. Locally in Middleton, there has been a decreasing trend in all 3 national screening programmes. In Beeston, there appears to be a low prevalence of cancer in the area, however there is also a low percentage of cancers diagnosed through the 2 week wait referrals. The area also has higher did not attend rates to 2 week wait referral appointments and below national average on all national screening programmes, in particular bowel uptake is low. As a result, a number of practices in this area have some funded time through the CCG for a Practice Based Bowel Screening Champion.

Care Navigation Leeds and York NHS Partnership Foundation Trust (LYPFT) have appointed a nurse to a Care Navigator role based at The Mount. She attends operational delayed discharge forums at Leeds Teaching Hospital Trust (LTHT) as well as The Mount in order to co-ordinate arrangements for people with complex needs in dementia, regardless of hospital setting.	The role has become a valued member of the LTHT Operational Discharge Group, ensuring people are referred to the LYPFT Enhanced Care Homes Team. The role works in partnership with commissioners to invite interested providers to discuss individual needs, develop the care home market and support individuals to leave hospital.
Enhanced Care Home Team The initiative aims to reduce avoidable delays that older people with complex dementia needs face when being placed from hospital beds to suitable long-term care home placement. They do this through proactively pursuing care home placement options as well as then providing care homes with rapid access to intensive short term input/care.	Between July and December 2018, successfully placed 42 service users to care homes who otherwise would have been in hospital for longer. There are a number examples of supporting care homes in admission avoidance. This service has now received recurrent funding.
Medicines and Consumables The objective of this programme is for patients to receive the medicines that are the best value for them and for Leeds.	Significant progress has been made in making the best use of the Leeds pound whilst improving service in the following areas; ○ Stoma care ○ Oral nutritional supplements ○ Silk Garments ○ Wound Dressings

Urgent Care and Rapid Response - "I get rapid help when needed to allow me to return to managing my own health in a planned way"

Progress is being made with activities to:

- Review the ways that people currently access urgent health and social care services including the range of single points of access.
- Look at where and how people's needs are assessed and how emergency care planning is delivered (including end of life) with the aim to join up services, focus on the needs of people and where possible maintain their independence.
- Make sure that when people require urgent care, their journey through urgent care services is smooth and that services can respond to increases in demand.
- Change the way we organise services by connecting all urgent health and care services together to meet the mental, physical and social needs of people to help ensure people are using the right services at the right time.

Recent successes under this programme include:

Project and Description	Successes
Urgent Treatment Centres (UTC) This programme will develop UTCs across the city. UTC's offer urgent primary care, both for minor injury and minor illness. The proposal is to develop five UTC's in Leeds. Three UTC's will be in the community (St Georges, Middleton, Wharfedale, Otley and potentially in Seacroft) and two will be co-located at the A&E departments (St James University Hospital and Leeds General Infirmary)	The St Georges Centre in Middleton, South Leeds was formally designated as an UTC in December 2018 by NHS England. This means it meets the national mandate as set out by NHS England. A formal 12 week public engagement programme which sought views on the proposals for UTC's in Leeds has recently been undertaken-analysis is underway during May 2019. The development of Urgent Treatment Centres are underway at the Wharfdale site and at St James's Hospital. Further information on Urgent Treatment Centres will be coming to the next round of Community Committees
Clinical Assessment Service (CAS) This project aims to provide a Clinical Assessment Service for the Leeds population. People who ring NHS 111 will receive a clinical assessment over the telephone, reducing the number of people who need to receive a face to face appointment. The ambition is for all single points of access to link into the CAS, and for the CAS to book appointments into services when a face to face appointment is required. This will standardise and simplify access into health and care services	The 6 month pilot has been evaluated. Findings show that 50% of all calls to the Leeds CAS were dealt with over the phone. The learning from the pilot is helping to inform how the service can expand for Phase 2. The scope for Phase 2 (2019/20) is currently being determined.
High Intensity Users Project The service provides tailored support to people who attend A&E frequently to address underlying social, medical and mental health issues.	Those that use the service for three or more months have been found to have better experiences and outcomes – being supported to access the services they most need rather than A&E. Emergency Department attendances and ambulance conveyances were reduced by 53% over the 12 months for the 72 people the service worked with in the last year. This service is ongoing.

Yorkshire Ambulance Service (YAS) YAS are now able to refer patients directly into the Leeds Frailty Unit at St James's hospital. This means that ambulance staff can assess patients they are called to attend to with a 'frailty score' and determine if they may be best supported in a specialist unit that supports people with similar conditions. This means patients may bypass a potentially delaying and stressful period in the hospital Emergency Department.	The project allows ambulances to take people straight to the most appropriate place for their care giving them the best chance of avoiding admission. In the first 15 days 18 people benefitted from this pathway.

Collective resource areas that enable transformation

Estates successes include:

- Closer working with Planning on ensuring sustainable community health provision in light of housing growth (actual and target figures in the Site Allocations Plan)
- Focused work on priority neighbourhoods, linking closely with the Neighbourhood Improvement programme and Localities team.

Digital successes include:

- Introduced some significant shared IT services between LCC, CCG, LCH and GP Practices
- Added Children's data in to the Leeds Care Record
- Introduced a new way of sharing child protection information between urgent and emergency care services and social care
- Increased the number of GP Practices taking appointment bookings directly from the 111 service

Workforce successes include:

- 130 people from Lincoln Green attended recruitment events held in the local community in April. All attendees signed up for courses or interviews and 3 nurses from overseas are joining Leeds Teaching Hospitals Trust.
- 300 of the Leeds 'One Workforce' have already attended the System Leadership Programme which has the objective of growing a connected community, who have people of Leeds at the heart of everything we do.
- The first Leeds wide Health and Care Careers and Recruitment Event held on 14 May 2019.

Appendix 5

Community Committee	LCP Footprint	Most deprived 5th of Leeds	2nd most	mid	2nd least	Least deprived 5th of Leeds	Grand Total
Inner North West	Armley	104					104
	Beeston	585					585
	Burmantofts & Richmond Hill	717	5,219	1,241			7,177
	Central		1,987		974		2,961
	Holt Park		4,826	4,161	292		9,279
	LSMP		8,177	20,634			28,811
	Middleton			273			273
	Woodsley		6,410	27,749	8,243	11,429	53,831
Inner East	Burmantofts & Richmond Hill	18,219	5,027				23,246
	Chapeltown	2,109					2,109
	Crossgates	1,780	6,392				8,172
	Harehills	36,490					36,490
	Seacroft	27,187					27,187
Outer North West	Aire Valley		5,942		13,295	23,818	43,055
	Central					3,029	3,029
	Holt Park		1,714	1,003	14,278	6,559	23,554
	Otley				6,367	15,224	21,591
	Wetherby					38	38
	Woodsley					1,672	1,672
Outer South	Beeston			144			144
	Garforth/Kippax/Rothwell			19,395	7,816		27,211
	Middleton		2	8,384			8,386
	Morley		15,213	3,315	30,981	6,501	56,010
Inner South	Armley	1	68				69
	Beeston	22,019	18,104	105			40,228
	Burmantofts & Richmond Hill	1,869		670			2,539
	LSMP			300			300
	Middleton	19,377	23,405	4,000			46,782
Outer East	Burmantofts & Richmond Hill	1,672	153				1,825
	Central			1,652			1,652
	Crossgates	5,363	1,946		17,030	6,096	30,435
	Garforth/Kippax/Rothwell			3,205	26,130	8,267	37,602
	Seacroft	2	7,508	6,660			14,170
Inner North East	Central	11,973	47	16,833	18,618	15,081	62,552
	Chapeltown	7,847					7,847
	Harehills	634					634
	Seacroft			7,694			7,694
	Woodsley		611	1,141		763	2,515
Inner West	Armley	7,984	4,954				12,938
	Bramley		17,628	1,352			18,980
	Pudsey	6,209	1,469	9,155			16,833
	Woodsley	1,908	17,626	8,182		599	28,315
Outer West	Armley	1,001	6,081	3,097			10,179
	Beeston			2,513			2,513
	Bramley	5,215	6,530	1,489			13,234
	Pudsey	126	7,855	25,269	6,217	8,372	47,839
Outer North East	Central		6,818		1,653	16,278	24,749
	Garforth/Kippax/Rothwell					6,701	6,701
	Seacroft		4				4
	Wetherby				6,192	26,692	32,884
Grand Total		**180,391**	**181,716**	**179,616**	**158,086**	**157,119**	**856,928**