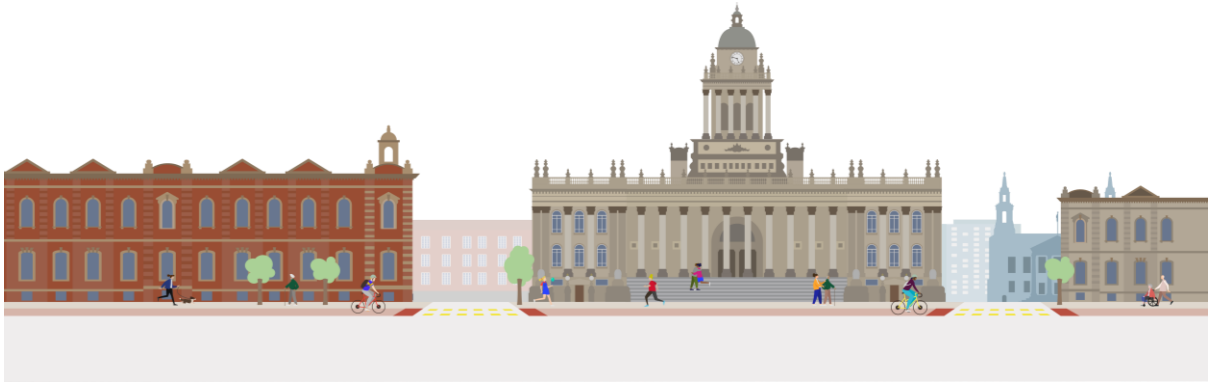
Leeds Health & Care Partnership

Better Care Fund Narrative Submission

2023-25

DRAFT: June 2023



Contents

Bodies involved strategically and operationally in preparing the plan

Plans reflect the ongoing work of the Leeds Health & Care Partnership, NHS bodies, Local Authority, Care Home and Home Care providers along with colleagues from VCSE through multiple forums within the Partnership.

Stakeholder Engagement

Our Health & Care System partnership working allowed for this document to be developed collaboratively at weekly forums, such as the system resilience operational group with representation from all health and care organisation and our System Coordination structure with third sector representation. In addition to sharing at these routine forums we have held a dedicated engagement session with care home and home care providers in the city.

The narratives and the plans are all, where relevant, developed in partnership with our Housing/DFG partners who are within the same authority. We work closely with housing partners who are located within LCC and are a pivotal part particularly of our accommodation-based areas of integrated commissioning

Governance

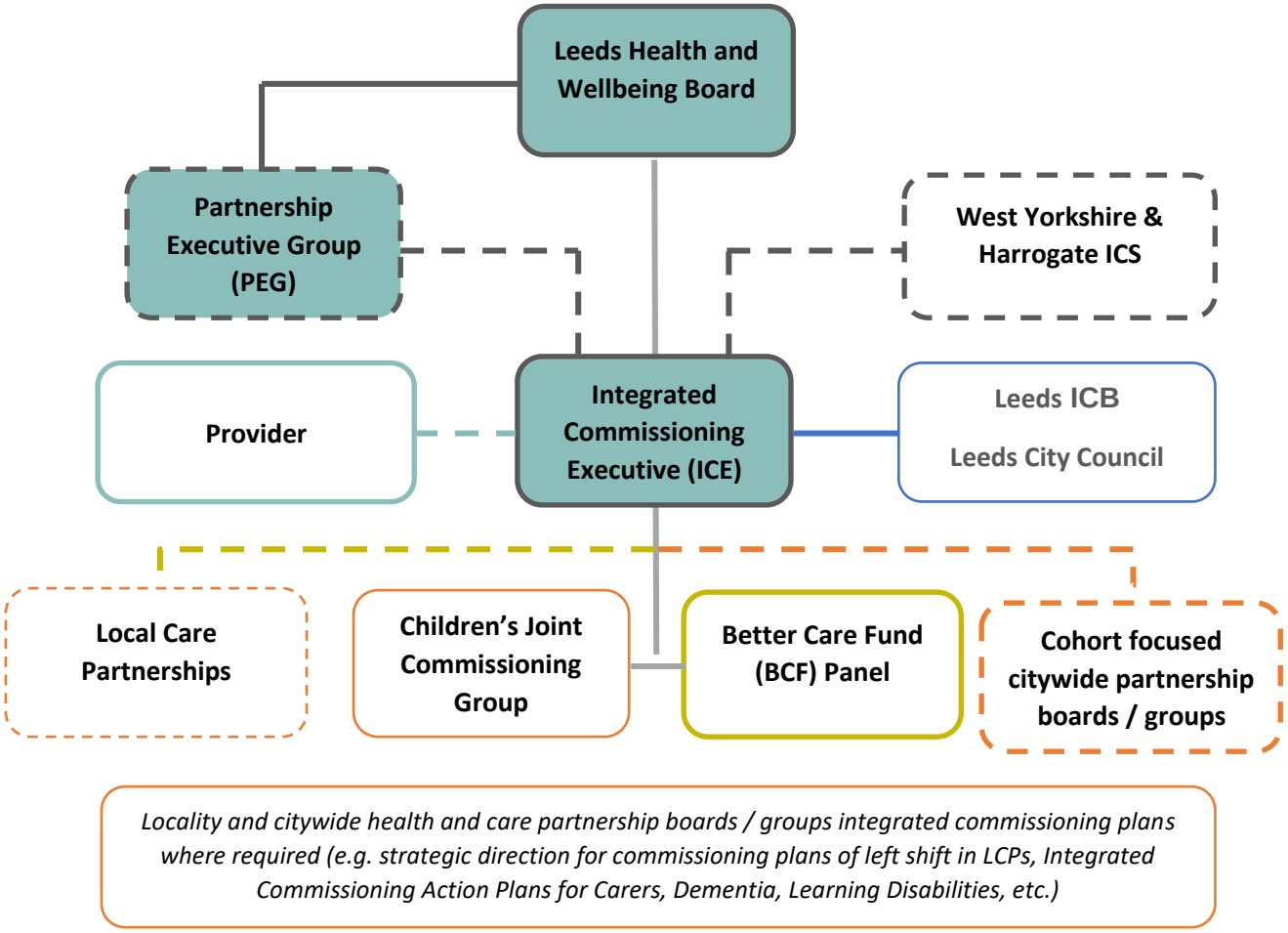
The governance of the BCF is overseen by the Health and Wellbeing Board in Leeds. The two delegated senior officers for this are the ICB Director of Pathway Integration in Leeds and Executive Lead for Discharge and Deputy Director of Integrated Commissioning (joint post, based in LCC). They are jointly responsible for integrated commissioning areas, identifying opportunities for spend and reinvestment, and for working across the system to maximise the outcomes of the BCF allocation.

The spend and return on investment of each element of the BCF is monitored by the Integrated Commissioning Executive (ICE), which is informed from relevant Committee of the ICB. This is in conjunction with the Programme Governance surrounding our Home First transformation programme, which is jointly commissioned and delivered by the NHS and Local Authority in Leeds

Monitoring of capacity and demand across our integrated system occurs weekly through partnership system leadership meetings supported by a data dashboard. Our Integrated Commissioning Executive (ICE) of senior leaders across NHS and Council oversees all areas of integrated commissioning and continues to look for every opportunity to work together to maximise outcomes/value for money.

ICE works with wider providers including the Third Sector through a range of mechanisms principally the Leeds Health and Wellbeing Board, the joint executive function of that board and the Partnership Executive Group (PEG) as part of delivering the Leeds Health and Wellbeing Strategy. ICE provides quarterly updates to the HWB on the progress of plans.

Figure 1: Leeds Health & Care Partnership Governance Structure



Executive Summary

- **Priorities for 2023-25**
- **Key changes since the previous BCF plan**

The priorities within the Leeds Health and Care Partnership remain those set out through the Healthy Leeds Plan and our ambition for Leeds to be a healthy and caring city for all ages where people who are the poorest improve their health the fastest. The Leeds Health and Care Partnership has a strong population health approach, which is now being further embedded through population boards focusing on the needs of key populations including those living with frailty, those living with long term conditions and those at the end of life.

In delivering our plan we focus on prevention, reducing health inequalities, improving outcomes and experience for people, and ensuring effective use of resource. This ambition will be delivered by focusing on key priority areas in the work of our Population Boards.

- Reducing avoidable unplanned utilisation across health settings,
- Increasing early identification and intervention with a focus on the 26% of people in Leeds who live in the 10% most deprived areas nationally.

Alongside this we have a collective vision to improve the flow across the system and have merged our previous transformation work, System Flow, Active Recovery, Enhanced Community Response, among others, into an overarching Home First Programme. The Home First Programme is developing and implementing a new model of intermediate care services to achieve more independent and safe outcomes, helping more people to stay at home, whilst improving the experience for people, carers, and staff. **The vision is to achieve a sustainable, person-centred, home-first model of intermediate care across Leeds that is joined up and promotes independence.**

The Home First programme will embed a structure that reduces our beds utilisation as a city and allows more people to receive support in their own homes, taking us closer to the pathway outcomes modelled by John Bolton. We have cross system engagement and leadership in this work programme to ensure engagement and ownership from all sectors in Leeds. Our collective priority focus for the coming 2 years will be to deliver on the benefits set out through this programme of work.

Our improvement work is informed by feedback from service users and a Healthwatch report highlighting opportunities to improve the user experience of hospital discharge processes within Leeds.

N.B A refresh of the Healthy Leeds Plan is currently being completed

National Condition 1: Overall BCF plan and approach to integration

Embedding integrated, person-centred health, social care and housing services

Our joint priorities for 23-25 are set out in the Home First programme, enabling more people to be independent for longer in their own homes. This is a significantly ambitious programme of work that will be delivered through 5 key project areas designed and delivered jointly between the NHS and local authority teams.

We have a strong history of jointly commissioning services within Leeds including our joint equipment and rehabilitation/ short-term bed provision, which support discharge from hospital and admission avoidance. We have plans to further expand this through our HomeFirst work with work to create a shared Active Recovery service. This will combine and build on the work of the current local authority Reablement service and the NHS community nursing and therapy neighbourhood team service that supports people in the community to provide an integrated service offer across health and social care with one Active Recovery team.

The coordination of discharge from hospital is delivered by an integrated team within our Transfer of Care (TOC) Hub. We are working to continuously improve the service offer and streamline pathways to reduce delays for people waiting to be discharged from hospital and utilise the whole health and social care workforce to reduce the need for people to have to tell their stories more than once. We are currently focusing on expanding our trusted assessor pathways to support the workforce challenges within ASC and reduce delays across our health and care services. In addition, we have invested in housing officers and mental health support to further enhance the offer of our integrated transfer of care hub. We also have input from Carers' Leeds and Age UK to ensure we consider the options for accessing VCSE as well as statutory options.

We also have an integrated approach to mental health commissioning and a fully integrated service for people with a Learning Disability. This work has successfully meant that virtually all of our previous long stay hospital patients with a Learning disability have now been provided with community based care solutions.

All our work around Intermediate Care and support to people on discharge/prevention of admission has health and care representation embedded within it as well as 3rd sector representation. We continue to work to reduce the delays and out of area placements within our mental health services and will be implementing improvement workstreams during this BCF period based on the evidence gathered at our Mental Health service MADE in June 23.

Our key changes to services commissioned in 23-25 is to reduce the proportional reliance on bed-based services within the city by expanding our support at home offer through the Home First programme. This will be collectively contributed to by a range of schemes funded through the BCF.

National Condition 2:

Integrating care to support people to remain independent at home

The Leeds Health and Care Partnership has an ambition to be a healthy and caring city for all ages where people who are the poorest improve their health the fastest. We have agreed two key objectives to support the delivery of this:

- Reducing avoidable unplanned utilisation across health settings,
- Increasing early identification and intervention with a focus on the 26% of people in Leeds who live in the 10% most deprived areas nationally.

We already have a multitude of services and schemes in place to support the delivery of these; not all are currently commissioned through the BCF but the LA and NHS commissioning. Service and schemes include:

- A Leeds Equipment Service focused on anticipatory care for people who are frail. This scheme has encouraged identification of those who are most at risk of losing their independence/deterioration, and provision of support to these people.
- Primary care embedded within the local care partnerships with third sector partners as set out in the Fuller stocktake
- A strong VCSE presence in all communities with the Enhance service of 10 VCSE providers, providing own support in communities for those without family to improve self-care and asset-based approaches.
- A self-management team who are actively engaging across our services to support people and their families to better manage their own conditions.
- An Active Recovery service that supports people at home by integrating the services of the Reablement and Neighbourhood Teams
- Same day response services within primary care to enhance access for those who would otherwise seek support from the hospital ED
- Strong links between our Same Day Emergency Care (SDEC) work and our community response, increasingly identifying opportunities to return people to their own homes from ED or SDEC rather than admissions
- Further investment in community staffing including additional night sitters and therapy staff to provide care for people in their own homes and reduce our reliance on bed-based care.
- An established and expanding Home Ward for Frailty and Home Ward for Respiratory service that provides enhanced care for those who would otherwise require hospital admission
- A Rapid Response to Falls service delivered by our telecare team that avoids hospital admissions and ambulance attendances through joint working with the Primary Care Access Line and Yorkshire Ambulance Service

- An Integrated Falls Assessment Service providing a virtual MDT with Geriatricians, an, Advanced Therapy Practitioner and the Primary Care Network Pharmacy Lead for Frailty. This service provides a citywide single point of access for falls triage and assessment identifying the most appropriate pathway for care.
- RESTORE2 and I-Stumble training roll out with the Leeds Care Homes

We are committed to a strength based social work approach and our Asset Based Community Development approach, which work across the system to personalise the support for people at home. This culture and our enhanced care at home offers will reduce the number of residential and nursing home admissions in the city per 100,000 population.

We have embedded a mental health worker into SDEC and ED teams too, to pay particular attention to the needs of people with MH problems on the verge of admission to see if we can maximise their discharges/admission avoidance, recognising the particular challenges that an inpatient setting can place on a person with mental health needs or cognitive impairment. We are still progressing an additional bedded unit for people with complex dementia, but this has been significantly delayed by difficulties in finding builders to do the work. We have, however, worked closely with an independent care home to increase our capacity for people with dementia needs.

Demand and capacity for intermediate care to support people in the community.

During 2022/23 we saw an increase in the attendances to Emergency Departments in Leeds, this was not associated with an increase in admissions due to the city's focus on admission avoidance through the same day service offers. We continue to expand and build upon our admission avoidance services through SDEC and the virtual wards in particular. The virtual wards services for frailty and respiratory conditions were able to meet all the seasonal demand for these services throughout 2022/23. We have also expanded our Community IV antibiotics offer.

In response to seasonal pressure, we invested in the primary care same day services to avoid attendances and admissions to hospital. The establishment of an Acute Respiratory Illness Hub for children with respiratory conditions had a high level of demand, over 330 appointments per week at its peak. This was a successful service helping to mitigate the impact of flu and RSV of the acute hospital by managing the conditions in the community.

The embedding of our Transfer of Care Hub and our work on system visibility means we have an ever clearer picture of what people need on discharge from hospital and discharge from intermediate care services. We have identified a need for more rapid assessment and home care offers out of hospital, and earlier access to bedded facilities to enable continued recovery and assessment for people who may need long term care. Conversely, we are beginning to see a reduction in the need for therapeutic beds, as more of these people are identified for care at home. This is informing the additional productivity and capacity we need in these service areas. Some of this will be from increased funding but we have also recognised the potential for increased capacity by reducing waste in our processes such as repeated assessments and, where appropriate, allowing more information from partners to be used to inform Care Act decision making.

Our city's transformation programme is focusing on the Home First service offer and working to reduce the reliance on bedded services by expanding the available options for care at home. The pathway for community step-up into intermediate care services is being redesigned in this programme to improve access. The capacity and demand modelling to support the BCF reflects the percentage increase we expect to see through improved processes and increased capacity in the reablement at home service as the Active Recovery offer increases in Leeds.

Changes and New schemes for 2023-25

We have a strong community response offer and virtual ward provision already. We are enhancing our decision making, both with the hospital and with YAS to help divert people into these responses rather than into admissions. We are for example currently testing out the use of a Clinical Assessment Service to see if we can further increase diversion opportunities. We already work closely with YAS to divert people who have fallen without harm to our community falls services. Community Neighbourhood Teams provide three Unplanned Care Hubs across the city for urgent response and in partnership with Yorkshire Ambulance Service directly treat YAS Category 3 and 4 patients to provide direct care at home and capacity release for the ambulance teams.

Our Home First programme (described as above) is our key driver for reducing admissions to residential and nursing care – we believe that by reducing 'lost bed days' that lead to deconditioning and more of an emphasis on rehabilitation, recovery and care at home, we can delay the requirement to rely on long term care settings. This ambition will also require support for carers and families, which is built into our approach.

Figure 2: Details of programmes of work that sit within the Enhanced Care at Home Programme within the HomeFirst Programme

National Condition 3

Approach in your area to integrating care to support people to receive the right care in the right place at the right time

In Leeds we work collaboratively to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Our jointly commissioned and delivered Transfer of Care Hub works to support the discharges of people from the hospital into the most appropriate care, following the home first ethos. We are continuously working to streamline the processes and improve the service user experience of transfers of care. This approach is supported through the use of Delegated Duties and Trusted Assessor models to support the completion of Care Act assessments in a timely way through efficient use of the available staff skill mix.

As mentioned, previous our ambition to redesign our intermediate care services to align with the home first ethos is being delivered through our jointly commissioned transformation programme – **HomeFirst**. The programme consists of five projects with the following objectives:

Active Recovery at Home –developing a joint short-term home-based rehabilitation and recovery offer with the required capacity and approach to support more people to achieve more independent outcomes.

Enhanced Care at Home (previously known as Enhanced Community Response) – developing fast and effective care outside of a hospital setting to safely reduce unnecessary admissions and help people to return home more quickly after receiving care in hospital, including support for carers.

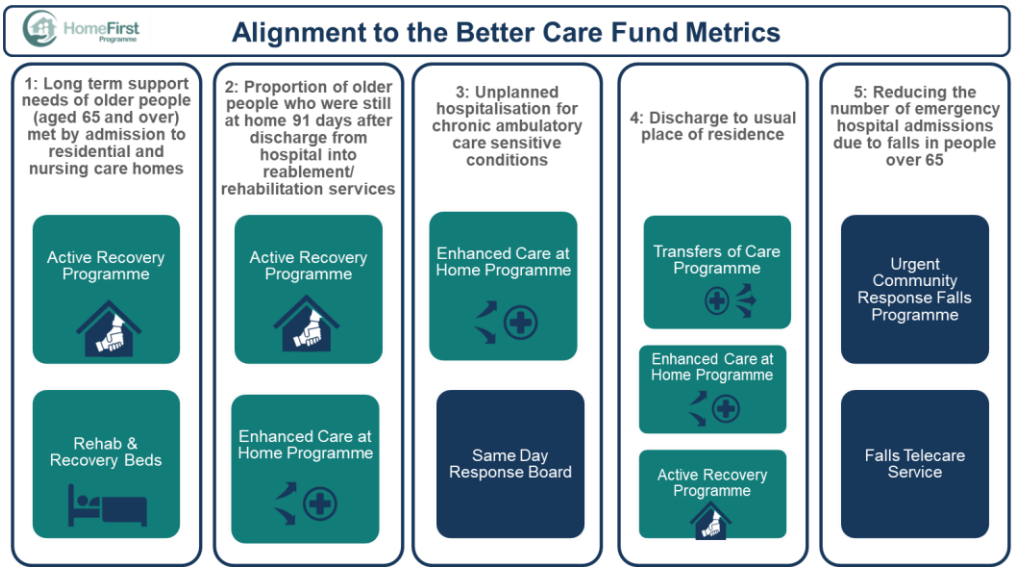
Rehab & Recovery Beds–redesigning bed-based intermediate care to maximise the number of people that can return to their own home following a stay in a short-term bed.

Transfers of care –redesigning interfaces between services for simple, quick, and effective pathways, and improving support to people who are discharged from hospital and their families and carers.

System Visibility & Active Leadership–embedding a culture of data-driven decision making with the visibility to see how people are moving through our health and care system, working together to help more people return or stay at home.

There are several cross-cutting enablers that will support all projects. These include health equity, patient and carer experience, contracting and commissioning, and staff engagement.

Figure 3: Details of how the HomeFirst Programme will contribute to the delivery of the BCF key metrics



The Additional Discharge Funding has been further used to support our tactical response to system flow pressures in alignment to our Home First programme. Whilst the HomeFirst programme will work to mitigate the anticipated growth associated with demographic growth in the aging population, we recognise the growing dependency will increase the cost of care for those within care homes. Due to the current climate of austerity within the population, we anticipate that a higher proportion of people will be entering council funded residential & nursing care at an earlier stage than previously and thereby increase the relative costs to the local authority. To support this demand and in response to a reliance on agency social workers due to the challenges in recruitment we have dedicated funds to a substantial recruitment campaign within the social care workforce. Accordingly, the additional discharge monies have been jointly invested in:

- Additional community staff including night sitters, self-management facilitators and therapists
- Additional social workers
- Investment in our integrated Transfer of Care Hub, including embedded housing workers
- Additional hours of home care
- Additional care home capacity for those who cannot be cared for at home over winter
- Transitional housing and primary care for homeless population and support to hospital teams to access housing options

Demand and capacity for intermediate care to support discharge form hospital.

Learning from 2022/23

Our seasonal demand planning evidenced an increase demand for hospital services over the winter months, as a system we serviced this demand through the opening of additional G&A capacity and focusing on increasing services in the community to support discharge.

The establishment of our TOC hub has implemented processes that provide us with assurance of the appropriate level of intermediate care being prescribed at the point of discharge. We saw increase demand for intermediate care services following hospital discharge. This was particularly acute over the winter period where it was accompanied with increase dependency at the point of nR2R. To support the increase dependency and demand the system utilised intermediate care beds to allow for Discharge to Assess. We have invested in additional community staffing to support the growing demand and dependency in the community.

The limitations of social work capacity in the city have impacted on the amount of time people are in intermediate care services before they are discharged to their long term care service. Agency teams have been utilised to mitigate the level of social work vacancies that have arisen in the last 18 months, in line with national trend. A number of plans are in place including overseas recruitment, attraction and retention strategies for registered and non-registered staff, delivery of plans within the Leeds and Wakefield Social Work Teaching Partnership to increase the number of students, and a concerted wellbeing offer. We are reviewing our processes and maximising the use of Trusted Assessors and Delegated Duties at transitions of care to support improved capacity within our intermediate care services.

Approach to Capacity and Demand

Our city's transformation programme is focusing on the Home First service offer and working to reduce the reliance on bedded services by expanding the available options for care at home. These changes are reflected in our capacity and demand modelling for the BCF alongside anticipated seasonal demand changes.

Our capacity and demand modelling for hospital discharge reflects the proportional waterfall effect of the opportunities identified through the Home First diagnostic to:

- Diversion from short-term residential care into pathway 2 rehabilitation beds
- Diversion of demand for rehabilitation in a bedded setting to rehabilitation at home and reablement at home
- Diversion away from short term domiciliary care into the improved capacity in the reablement at home services.

This transformation programme will be fully implemented by August 2024 and the capacity and demand model reflects the shifts within the system pathways as we transition through the first half of the implementation phase

Progress in implementing the High Impact Change model for managing transfers of care

Change		Matrix level	Details
1	**Early discharge planning**	**Established**	Our jointly commissioned transfer of care hub is now embedded in Leeds. We are working to increase the presence of the transfer of care hub staff and the social work teams on the wards to facilitate expert input into early discharge planning
2	**Monitoring and responding to system demand and capacity**	**Exemplary**	We have an established System Resilience operational group who come together weekly to update on and provide mutual aid to mitigate live pressures within the system. In addition to this we now have a system visibility dashboard, containing live data that is allowing us to take more proactive action as a city through our weekly Active System Leadership meetings.
3	**Multi-disciplinary working**	**Mature**	The integrated TOC hub and decision-making structures within the city are supporting us to work and make decisions in a multi-disciplinary way. We are working towards the exemplary criteria by redesigning services to allow for a 'pull' model out of hospital that supports people to be assessed in the community.
4	**Home first**	**Established**	We are working towards our vision of Home First through our transformation programme, which is expanding the offer of home-based services. We are working to become meet the mature criteria by establishing new pathways to ensure wherever possible, people are supported to be assessed in their usual place of residence and decisions about long-term care are not made in hospital.
5	**Flexible working patterns**	**Established**	Hospital, intermediate care services, including Reablement, and the transfer of care hub work across 7 days a week. Demand for discharge services is lower at the weekend. Most care homes and home care providers accept new clients and existing clients regardless of the day of the week. Social worker weekend working is currently through voluntary rota contributions
6	**Trusted assessment**	**Established**	We are currently further investing in and expanding the use of trusted assessors both on hospital discharge pathways and across our community bed base. We are working to complete fewer assessments in hospital through our Home First programme

7	**Engagement and choice**	**Established**	We ensure clients are involved in decision making from arrival and their preferences are recognised throughout the care journey. We have a current working draft of our new choice policy which has been developed in consultation with staff. Upon approval by the ICB we will be sharing updated letters with service users and their families to ensure communications with people and their families is consistent across all health and care settings.
8	**Improved discharge to care homes**	**Mature**	Relationships with care home providers in Leeds are well established and homes generally offer flexible admission times to accommodate any on the day delays. Primary care and community services in reach into care homes to avid unnecessary admissions into hospital
9	**Housing and related services**	**Established**	We have a good understanding of housing and homeless issues in Leeds and how these impact on discharge. To move us towards exemplary we have housing support workers joining the TOC team in June and become part of the discharge MDT and improve timely access to support.

Duties under the Care Act

The Better Care Fund supports the delivery of a range of services including those that enable delivery of a preventive approach within adult social care including the reablement service, equipment service and telecare – these are aimed at enabling independence and delaying and preventing access to long term services, therefore reducing demand on social care budgets. The Adult Social Care Discharge fund has enabled the provision of short term residential care and social work support to enable people to be discharged from hospital and return home with a care package to meet their assessed needs.

Supporting unpaid carers

We recognise the critical contribution made by unpaid carers in supporting the achievement of our health and wellbeing priorities in Leeds. We commission **Carers Leeds** to provide information, advice and support for adult and parent carers in Leeds. In 2022/2023:

- Carers Leeds received 9,175 referrals, 3,506 of which were for carers not previously known to Carers Leeds.
- 89% of new referrals, where ethnicity in known, were from people stating their ethnicity as White British
- 77% of new referrals, where gender is known were from people stating their gender as women; less than 1% identified as transgender or non-binary
- Over 7,600 carers were subscribed to the monthly Carers Leeds newsletter
- Carers Leeds Advice Line received 9,418 separate contacts
- The Dementia Carers Team had 2,226 separate interactions with carers
- Hospital based Carers Support Team had 2,524 separate interactions with 228 unique carers
- Carers Leeds launched their new Carers Emergency Card in June 2022 and had issued 477 to the 31st March 2023.
- 238 support group sessions were held with a total attendance of 1,574 carers; there has been a steady trend from online back to face to face support groups

Time for Carers is a well-established, successful, and popular scheme which provides carers with a small one-off payment in order that they can take a short break from caring. It is also an effective way of reaching high numbers of carers, including those previously unknown to either Carers Leeds or Adults and Health. In 2022/2023:

- 565 carers received a Time for Carers Grant
- 85% of grant recipients were female
- 26.5& of grant recipients were from diverse ethnic backgrounds
- 54% of grant recipients used the grant to pay for a holiday, day out or weekend break

In 2022/2023, 2,380 carers were supported through respite/short break services which are provided directly to the person they care for

We are working with Carers UK and Carers Leeds to pilot a new **Digital Service Offer** which complements existing support for carers in Leeds by identifying and engaging carers at scale and offering online support to promote resilience, including information and signposting, emotional and 'self-care' support, online peer support. The digital service offer will utilise the Carers UK 'Digital Resource for Carers' platform. In the six months from October 2022, the number of carers in Leeds registered with the Digital Resource for carers has increased from 270 to 437.

Disabled Facilities Grant (DFG and wider services)

The Director of Communities, Housing & Environment, Leeds City Council is a member of the Health and Wellbeing Board and monitors progress on the BCF plans. Leeds City Council's Health & Housing Service is dedicated to promoting independent living for disabled and vulnerable residents in Leeds across all tenures.

The service is split into two main areas of work: Firstly, the adaptations team offers a full agency service for those residents who have applied for adaptations via DFGs or are Council tenants. The team has a wide range of Council procured contractors and extremely experienced officers that deliver adaptations in a speedy manner usually achieving the Government's DFG targets for installation month on month.

The second function of the team is to provide a comprehensive service that helps and supports disabled people to re-house if they are wishing to move or if their current home is not suitable to adapt. The Independent Living team award medical priority to disabled applicants in the City's choice based lettings scheme while the Occupational Therapy team assess suitability of homes for potential future occupation by disabled people who top bidding lists. The service also has a team of caseworkers who provide practical help and support to individuals and families who may struggle with finding and selecting properties on the online bidding system. This team also has 2 caseworkers that are based at the local hospital trust and are solely involved with providing housing solutions for disabled people who are fit for discharge from hospital.

Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of the DFG for discretionary services? (y/N)

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Leeds City Council has had a published 'Private Sector Housing Assistance policy' on the Council's website since shortly after the introduction of the RRO in 2002.

The Council's housing assistance policy has been up-dated on a number of occasions but has always been written in an open ended fashion to incorporate flexibility and discretion for the Council to promote independent living. The extent of the Council's discretionary programme can alter in any given year based on the demand for mandatory DFGs which, as a statutory duty, must always come first. Here are a number of examples of discretionary funding given in the last 2 years:

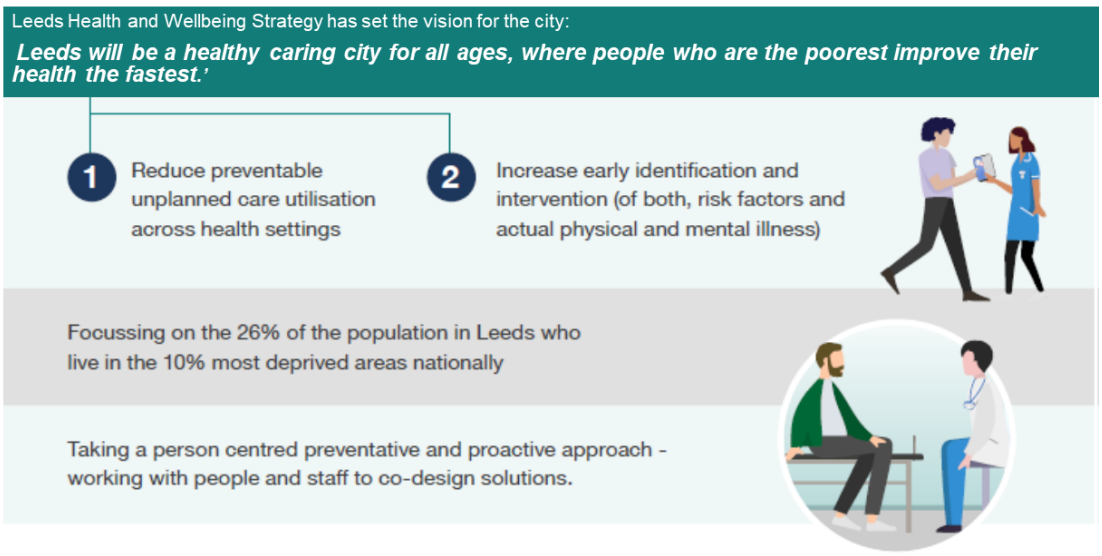
- Funding individual requests for funding from disabled and vulnerable people. Such as a request to repair a broken stairlift or similar disabled adaptations. All applicants are subject to a Council assessment of household finances to ensure there is financial hardship.
- Funding requests from external agencies, usually charities, for the provision of adaptations in their premises. Recent funding has been provided to St Georges Crypt and Turning Lives Around for disabled bathing facilities.
- Funding Occupational Therapists in Adults and Children's.
- Part funding improvements to heating systems for disabled people in conjunction with the Council's Sustainable Energy and Climate Change team.
- Funding caseworkers who work in Leeds Teaching Hospital Trust to support disabled people with Housing issues to help reduce the 'bed-blocking' crisis in the NHS
- Funding a repair scheme with Care & Repair (Leeds) Ltd to ensure the homes of disabled people are wind/weathertight, properly insulated and have effective heating.
- Funding individuals DFG schemes over the £30,000 mandatory grant.
- Funding support with DFG applicants who face financial hardship and can't afford the Government's means tested contribution.

Equality and Health Inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking into account of people with protected characteristics?

Our Health and Wellbeing strategy to improve the health of the poorest the fastest is delivered through our Population and Care Delivery Boards. Our population health approach continues to have a focus on health inequities and is creating a stronger data set for us to look at in terms of resource utilisation across both our areas of deprivation and our populations with protected characteristics. Details about this approach can be found in the Healthy Leeds Plan.

The Leeds Health and Care Partnership has agreed to focus on two collective goals to deliver on the city's vision.



Inequalities background in Leeds

Within Leeds 26% of the population live in the 10% most deprived areas nationally. The city is increasingly diverse with nearly 200 languages spoken and Black, Asian and Ethnic minority population represents almost a third of people registered with a GP in Leeds.

Our population has been expanding, specifically within our inner-city areas which are often our most deprived communities. These communities experience our city's worse health outcomes:

- There is a 14-year life expectancy gap for women and a 12-year life expectancy gap for men between some of our most and least affluent areas of the city

- Whilst people are living longer this is often in poorer health and with multiple long-term conditions. There has been progress in treating cancer, respiratory and heart disease but the premature mortality gap for these three areas have widened in our most deprived areas

- Almost 175,000 people in Leeds are living in relative poverty

- There has been a growth in in-work poverty with an estimated 74,000 working age adults across the city being from working households living in poverty

The population aged over 50 has grown by around 30,000 over the last 20 years. This demonstrates a 12% to 17% increase in each of the 50 plus age bands. Future population growth is predicted to be fastest amongst the 80+ age group which is expected to see a 50% increase over the next 20 years. The largest concentration of older communities is found within the inner-city areas. The proportion of people living with frailty within the most deprived communities is almost three times higher than those who live in the least deprived.

This growth in our elderly frail population is reflected in the plan and capacity and demand trajectories associated with the Leeds BCF investments, which is heavily focused on those over 65 years.

Our Tackling Health Inequalities Group (THIG) acts as an expert reference group to the Boards providing advice and expertise as well as challenge to the Boards to ensure we are focussing and taking actions to reduce health inequalities across Leeds. They have helped Leeds to develop its *Tackling Health inequalities Toolkit* that provides an evidence based and community informed framework for partners to use when addressing health inequalities.

In addition, the THIG has oversight of delivering the requirements of the national CORE20PLUS5 programme which is in place to inform action to reduce health inequalities at both a national and system level. Leeds is committed to understanding performance against the Core20PLUS5 and ensuring improvements in these key areas for both adults and children. However, whilst the CORE20PLUS5 is a priority for Leeds it does not cover everything that we are doing to reduce health inequalities. Each Population and Care Delivery Board has a specific remit to reduce health inequalities within their populations.

In addition to THIG, the Communities of Interest Network (COIN) aims to highlight and address the needs and challenges faced by groups and communities which experience the greatest inequalities, with a focus on health and wellbeing.

Delivering against our Health and Wellbeing strategy is an area we will be focusing on through our HomeFirst benefits realisation group, our other work on anticipatory care, proactive care and discharge. We will be looking at unwarranted variation in both resource utilisation and outcomes, with particular focus on the frail elderly population.

The outcomes for the HomeFirst Programme also marry what matters to people by maximising independence and reducing time spent in hospital or short term community beds. The Programme has a dedicated Engagement and Equity lead and will be using population health data and working collaboratively with THIG to consider how to address known inequity in how services are accessed. The Programme will be using 'I' statements to steer service design to ensure that services reflect what is important for people and their family/carers.

Through the BCF we are investing in our services for people experiencing homelessness or unstable housing including additional primary care support and transitional housing units to support at the point of hospital discharge. We continue to recognise the vulnerabilities associated with housing needs and have invested in invested in the housing posts and mental health services within our transfer of care hub.