Public Document Pack

HEALTH AND WELLBEING BOARD
16th SEPTEMBER 2019

SUPPLEMENTARY INFORMATION

Item 12.1 - Leeds Health and Care Plan: Continuing the Conversation (Appendix 1)

Item 14 - Draft Leeds Better Care Fund Plan 2019/20 (Appendix 1)

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Leeds Health and Care Plan 2019 – 2024

Improving health: transforming the system

Working draft Version 9

10/09/19

Editorial note: work is running in parallel to the circulation of this version 8 to continue incorporating feedback received to date on the previous iterations of the draft narrative.

Further work to be undertaken to improve flow, ensure plain English, consistency in language and tone etc

In the next iteration of the narrative we will continue to strengthen references around:

- *mental health; end of life; power of communities; Third Sector; children and families; learning disabilities; left shift; Leeds as a regional partner; carers; health inequalities etc.*

This document is for…	What you can do next…
• Colleagues working in decision making roles across our city's health and care partnership. • If you are in a position of designing, planning or evaluating the delivery of services in Leeds, then this narrative is for you. • It will also be useful for colleagues who manage teams, projects or processes. • Through these pages, we tell the story of what we are trying to achieve in Leeds, what health and care in the city will look like in the future, and the steps we're taking to help us realise our ambitions. • Further iterations of this document will follow for public and for all staff members.	• As you read through to the end of this document, you will be able to recognise your contribution to improving health and wellbeing in the city. • This narrative asks you to be a system leader! Whatever part of our system you work in, at whatever level, you can help by aligning with our wider ambitions, holding yourself and others to the standards we've agreed in our partnership principles, by making improvements where you see and hear they are needed, and forging strong connections throughout your organisation and beyond to make change happen. • This is your role within a thriving partnership; this is your role in ending health inequalities and transforming health and care.

Foreword

Dear colleagues,

It is an exciting and important moment in time that we write this. Our Health and Wellbeing Strategy is well established and has long been binding us together around our shared vision and outcomes. The first iteration of the all age Leeds Health and Care Plan in 2016 set the foundations for an ongoing conversation with citizens, staff and those that make decisions about how health and care services needs to change to ensure our health and care services are person-centred, sustainable, and fit for the future. We continue to reap rewards from the strong relationships between health and care partners and citizens. But now is the time to act on these achievements and take our ambitions to the next level.

It is time to think and act beyond our organisational boundaries, to work as Team Leeds, and to make the shift we know is needed to truly benefit our citizens both now and for future generations. Not all people who live in Leeds are having the life experiences we would want, and health inequalities are a contemptable part of life in this city.

So whilst delivering high quality services, we must also deal with the many interconnected factors that promote good health and good mental health for everyone - access to green space, strong communities, decent housing and the kind of inclusive growth that expands employment and opportunity for all. This is why we are refreshing the Leeds Plan; to strengthen our ambitions and collectively refocus our efforts to make significant and lasting change.

In true Leeds style, we will all ensure that people, especially those who experience the poorest health outcomes, are at the centre of all of our work and are enabled to improve their health faster than anyone else.

We can be proud of our health and care system in Leeds. But we take more pride in our shared ambitions and our determination to make things better. The Leeds Plan is helping to set the culture and conditions we need in our health and care system to make some of the most significant improvements that we'll see in our lifetimes. We can't let that pass us by.

Together, we demonstrate compassion, creativity, a willingness to take risks and try new things. We feel able to discuss, debate, and disagree, whilst never wavering from the big things - our commitment to people and striving for improvement.

Our strong relationships, and the diversity within them, must not be taken for granted. They allow us to take bold steps to be more than a health and care system – we are a partnership that takes decisions now that can impact positively in the short term as well as for our future generations.

Setting priorities, based on our work with individuals, communities and organisations, gives us all the chance to shape and influence and be system leaders at all levels of our work. The Leeds Plan makes our ambitions, our approach and our actions very clear. It not only guides what we do locally, but ensures we have a strong story to tell regionally and nationally. As such, our Leeds Plan is also used as our response to the NHS Long Term Plan and West Yorkshire and Harrogate Health and Care Partnership requirements.

It is an exciting and important moment in time that we write this; a moment that thanks you for all that you have done and asks you to work together to transform health and care, making Leeds the best city now and for future generations.

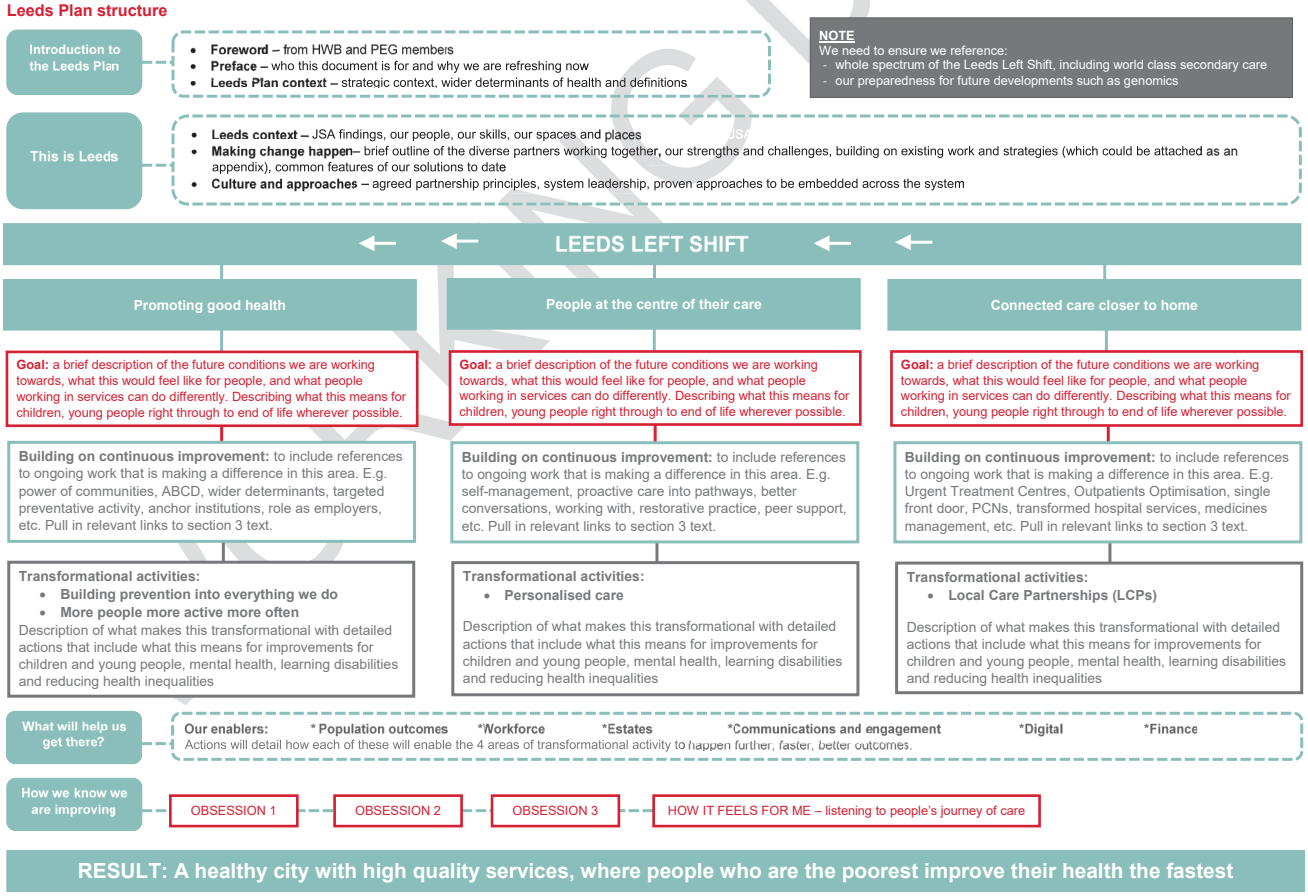
Signed: HWB and PEG

[Editor notes: rework the following two diagrams into one. To be updated to reflect final structure of the document. Diagram to be simplified to ensure readability. Will use style, colour theme etc of the diagram through the document to help reader navigate]

Contents

The heart of the Leeds Plan is structured around five sections that help drive the change we know is needed.

Leeds Plan structure



Leeds Plan context

The Leeds Health and Wellbeing Strategy outlines the conditions of wellbeing we want to realise for everyone in Leeds. 5 outcomes and 12 priorities give us a framework for citywide work that will make a difference to people and make Leeds the best city for health and wellbeing.

In response to this, the Leeds Plan is a declaration of what our health and care system will do to help realise these ambitions. It clearly states our goals and how we'll get there by working with people, communities and as a partnership. Actions captured within the Leeds Plan will also help us when we work with our wider partners, from education, housing, community safety, and beyond. In turn, this allows us to share what we are doing locally with our regional and national partners, giving confidence of our approach, our planning and our spending. As such, our Leeds Plan provides our response to the NHS Long Term Plan and West Yorkshire and Harrogate Health and Care Partnership requirements.

Our vision: for Leeds to be a healthy and caring city where people who are the poorest improve their health the fastest

Everything is connected

[Editor notes: the following ambition in the box below is an amalgamation of several ambitions around LHWS, IG, climate change. Needs to be signed-off by partners]

Our ambition: Leeds will be the best city for all ages – for now and for our future generations – a healthy, compassionate, climate resilient city with a strong economy, where people who are the poorest improve their health the fastest.

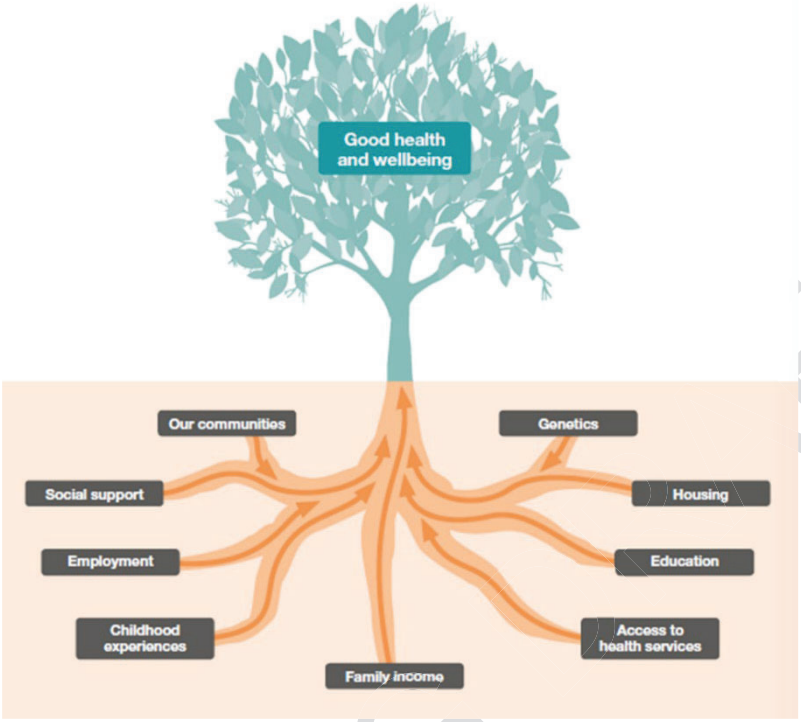
As little as 10% of our overall health and wellbeing is due to impact by healthcare or social care services[1].

Realising our ambition for Leeds to be the best city requires improvements in all the factors that support healthy lives, with a focus on three in particular: our health, our economy, and our environment.

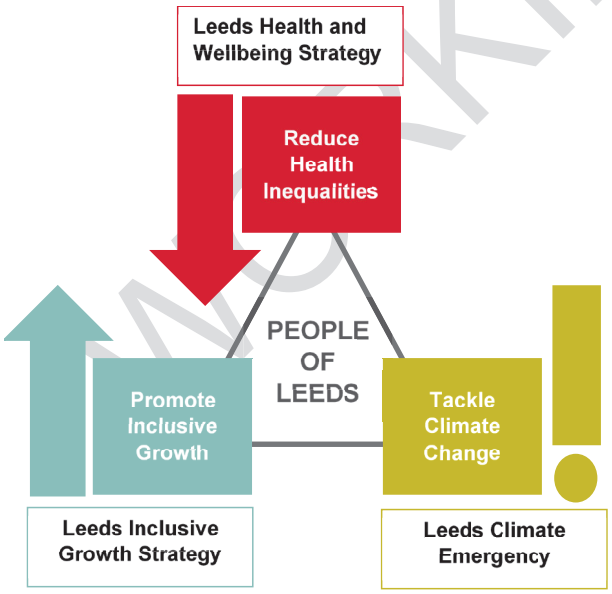
These are often referred to as the social determinants of health - these are the circumstances in which we are born, grow, live, work and age. They include our surroundings and how we travel through them, the food we eat, and the money we have, the quality of our education and our work, the

homes we live in, and the family, friends and communities we have around us[1].

Understanding and taking action on the wider context gives us a better chance of happy, healthier lives, within a resource efficient, fairer society.



As well as the Leeds Health and Wellbeing Strategy, the Leeds Inclusive Growth Strategy and the recently declared Climate Emergency provide the strategic contexts.



Health inequalities are the unfair and avoidable differences in people's physical and mental health across social groups and between different population groups. This has a direct impact on the quantity and quality of a person's life.

Inclusive Growth means all people and communities contributing and benefiting from our economy. This means tackling inequality, improving skills, increasing productivity and supporting people into better jobs.

Climate change is the result of human activities that release carbon dioxide and other greenhouse gases. This affects things that in turn impact on our health, including clean air, safe drinking water, sufficient food, and secure shelter.

[1] The Health Foundation

The Leeds context

The people we are and the communities we are part of

Leeds continues to attract people into the city to participate in its diverse and vibrant economy, culture and communities. However, we know that not everyone is currently benefitting from what Leeds has to offer. Of our estimated population of 785,000[2] over 170,000 people in Leeds live in neighbourhoods where it is recognised nationally that the factors combine that mean the people there will be more likely to live on a low income or be unemployed, and be living in poor health and in a poor living environment. One in five of our children in Leeds are living in poverty. Areas where children experiencing deprivation and poverty the highest are also those where we are seeing the highest growth in the number of children and young people. There remains an unacceptable health inequality gap in our city with 10 years difference between those the best and worst health.

Insight on inequality: 16 neighbourhoods in Leeds have been identified as being in the 1% of neighbourhoods that experience the greatest deprivation nationally. The population is growing quickest in some of these areas.

Our population is changing; growth continues to be driven mainly by inward migration. Meanwhile, the number of children and young people and older people is growing fastest in our poorest communities. Demographic changes and the impact of austerity has resulted in increasing numbers of people who have care and support needs. And many people experience isolation and loneliness as well as living in later life with multiple long term conditions. A key challenge is how to work with families, particularly those who are living in poorer neighbourhoods, to break the cycle of mental and physical ill health being passed on through generations. Different generations need the space and opportunity to come together to share their experiences, strengths and life skills with one another. There is a need to strengthen intergenerational work across healthcare in communities.

The relationships and resources in communities are building blocks for good health, for developing new and existing skills, and for looking after the spaces around us. Leeds has a wealth of brilliant and diverse communities – some are in communities where people live side by side, some are communities where people share a common heritage or identity, and some are where people have a shared interest or passion. These strong community links provide vital social and cultural connections that are proven to help keep people mentally and physically healthy.

Our Third Sector is a source of genuine pride in the city, with an enormous range of organisations embedded and working within communities to make a real difference. There are also more than 74,000 people in our city who give their time as a carer for relative or loved one, upon which we rely so heavily and without whom our city would be a worse place to be.

[2] https://observatory.leeds.gov.uk/wp-content/uploads/2019/04/Leeds-JSA-2018-Summary-Report.pdf

The skills we have and the jobs we do

Insight on inequality:
People with the shortest healthy life expectancy are three times more likely to have no qualification compared to those with the longest healthy life expectancy.

Learning underpins wellbeing and a good education improves access to well paid jobs and reduces exposure to life's challenges. We ensure particular focus on the Three As in school: achievement, attainment, and attendance. We enable all children and young people – particularly those learners who are vulnerable to poor outcomes to realise their potential.

Our economy is worth an estimated £21.3bn, making Leeds a major economic player both regionally, nationally and internationally. Leeds fared the recession better than many of our neighbours and, over the last decade, has consistently had the highest increase in employment rate of any comparable city. Leeds is a world leader in health innovation, with 22% of all digital health jobs across England and Wales being right here in Leeds. However, 90,000 adults in Leeds are offline and/or lack basic digital skills and these people are also more likely to be disabled, unemployed, on a low income or have low literacy and numeracy levels.

There has been a recent growth of in-work poverty, with an estimated 70,000+ working age adults from working households living in poverty and many caught in a trap of low pay, low skills and limited career progression. Leeds has a growing workforce challenge in being able to recruit and retain a range of health and care staff: including nurses across the whole sector and the new roles of social prescribers, pharmacists, physiotherapists, physician associates and paramedics in primary care as some examples of the priorities we are working to deliver. The whole system is fragile and, according to the Care Quality Commission, at a "tipping point". And despite increasing investment, more needs to be done to improve intra-city connectivity via public transport to tackle air pollution and to enable all of our communities to more easily access employment.

The spaces we live, play and move in

Leeds has green space equivalent to the size of 5,600 football pitches, yet not everyone has fair and equal access to these spaces or the benefits they offer.

Insight on inequality:
We continue to have spaces in the city where air quality is dangerously poor. Evidence shows that spending time in areas with high levels of air pollution can worsen symptoms of asthma, damage our lungs and reduce our life expectancy.

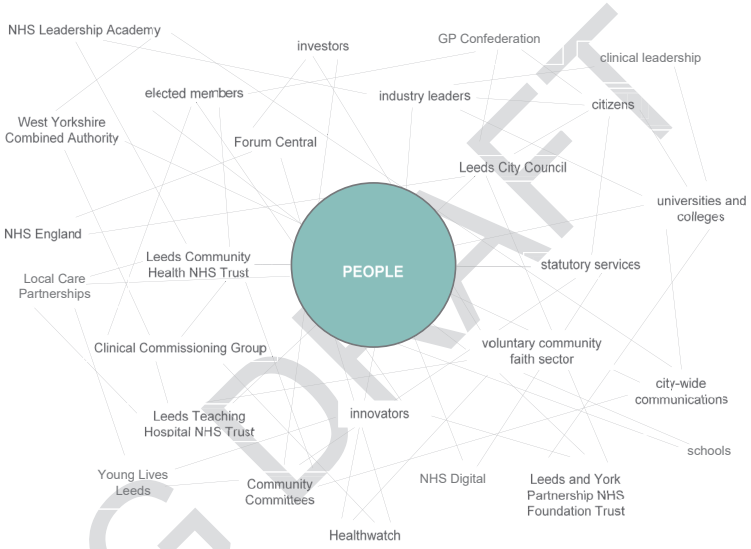
The climate we experience in Leeds is already changing and the impact of the increased regularity of extreme weather events is being felt. Leeds has successfully reduced its carbon emissions by well over a third in line with global agreements, ahead of most global cities, but has much further to go. Neighbourhoods where people can walk and cycle around easily, with good public transport and where everyone lives within reach of good green spaces helps to promote health and happiness. There is a need for better links between good public transport for affordable, easy access to health and care facilities for people when they need them.

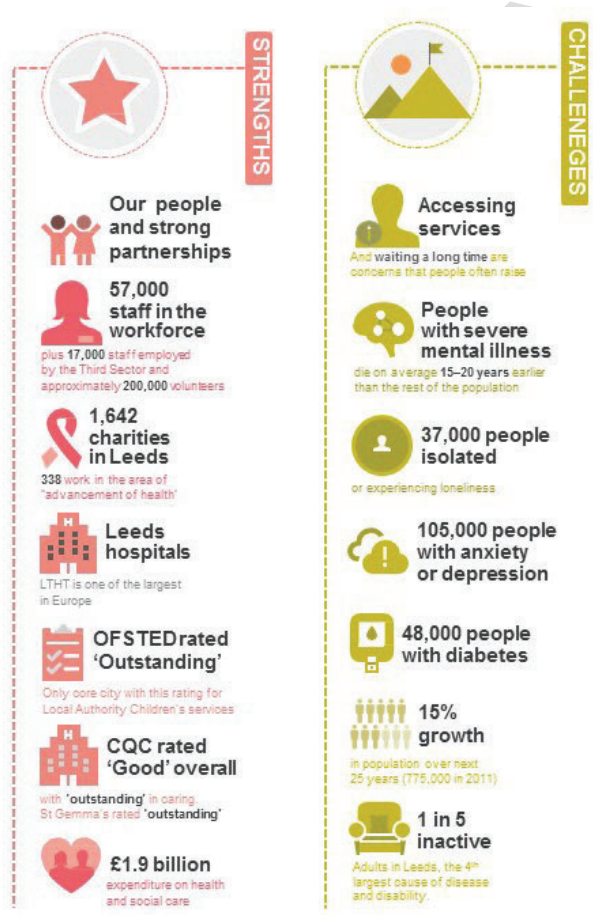
The social scene in Leeds is incredibly vibrant, but in work poverty, debt and problem gambling are all contributing to social inequality, meaning not everyone is benefitting from what our city has to offer.

Good housing is linked to good health; it means affordable, warm and stable homes that meet the diverse needs of the people living there, and helps them connect to community, work and services. Leeds faces the challenge of providing enough quality and accessible homes to meet the city's growing population, whilst protecting the quality of the environment and respecting community identity. The number of people who are homeless or living in temporary accommodation in Leeds is low compared with similar cities. However, whilst no one needs to sleep rough in Leeds, the number of people doing so is worryingly on the rise.

Our partnership context

People are at the heart of our partnership, which is made up of community, voluntary and faith groups, statutory health and care organisations, elected members, and academic and skills development bodies.





The value of our health and care partnership in Leeds lies in its diversity and inclusivity, the connections and strong relationships between us. This is what allows us to take action together – building on our strengths to meet and defeat our challenges. We share learning, identify where improvements can be made, and take risks together.

We view our resources in the city as our collective power, whether that's the talents of our citizens, the strength of our relationships, or our financial assets.

Our partnership will continue to grow, as we work more closely with regional and national partners, private sector businesses, SMEs, planning, housing organisations, transport, and more!

Making change happen

This understanding of our strategic contexts and the interconnected nature of what makes for good health provides the backdrop for the way we work together to deliver the Leeds Health and Care Plan. It helps us to define the culture and approaches to adopt as a health and care system to make change happen in Leeds. This is encapsulated through our unique features, our partnership principles, the way we develop and grow as system leaders and our common approaches.

Our unique features - that define our partnership

[Editor notes: do these add further to the partnership principles below?]

Connection: We all understand our role in addressing the interconnected, social determinants of health.

Collaboration: We share our ambitions and can achieve so much more together than one organisation, service, department, team, or individual ever can alone.

Challenge: We form trust based relationships that allow us to keep pushing ourselves and each other to do better, achieve more, and stand up to national scrutiny.

Compassion: We do the best for one another by tackling the causes of inequity, inequality, and injustice to create a better Leeds for now and for our future generations.

Confidence: We stay ambitious and do what needs to be done, even in times of adversity, and respond to our population to create an ever strengthening Leeds.

Our partnership principles - that guide the way we work together

Principles of our approach		
We put people first: We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce.	**We deliver:** We prioritise actions over words to further enhance Leeds' track record of delivering positive innovation in local public services. Every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £.	**We are team Leeds:** We work as if we are one organisation, taking collective responsibility for and never undermining what is agreed. Difficult issues are put on the table, with a high support, high challenge attitude to personal and organisational relationships.

[Editor notes: will emphasise system leadership and culture as two distinct but connected sections]

Our approaches – that shape what we do

[Editor notes: to add in introductory / connecting paragraph to this section. Reformat the boxes to ensure consistency. Create a diagram that presents the different approaches]

'Working with'
People are at the heart of all decisions around their health and care. We work 'with' people to find solutions rather than things being done 'to' people or 'for' them. We actively listen to people to understand what matters most. Through working in this way people feel empowered and in control of their health as their needs as they are being met in a way that makes sense to them.

Our solutions are co-designed, co-delivered, and co-evaluated with people wherever it is safe, appropriate and the right thing to do. We make sure this includes the communities who experience the greatest deprivation to reduce inequalities.

"As a Chief Executive working in the health and care system in Leeds, I can see how important it is that we make 'working with' people central to the changes we must make.
Our approach is about co-producing solutions with our citizens and, where we can, encouraging independence and resilience rather than creating dependence. Doing this is important because it gives people ownership of their own health and it makes our health and care system more sustainable."

Think Family
The 'Think Family' approach in Leeds supports all people to live in families, however they define family. We need to understand the unique circumstances adults and children live in and the strengths and resources within the family to provide for their needs. We know that the behaviour of adults has a significant impact on the lives of children. Problematic adult behaviour can lead to adverse childhood experiences that can lead to poor health and well-being throughout a child's life course. Therefore, we need to consider adults in their role as parents when engaging with them in any clinical or therapeutic intervention.

To 'Think Family' means that all staff remember that people rarely live in complete isolation, it is important to understand the needs of the wider family when working with a child, parent or adult.
To 'Work Family' means that all staff and services commit to working together, to talk more and to ensure that all staff working with children, young people and adults in a family plan and co-ordinate their work.

Asset Based
In Leeds our greatest strength and our most important asset is our people. Wellbeing starts with people: the connections, conversations and relationships we have in our families and communities have a huge impact on us and make us unique. It should therefore follow that people themselves are the catalysts for change in their local communities

We always focus on what's strong rather than what's wrong in order to understand people's assets within the context of their family, and the social, cultural, economic, and environmental influences on their health and wellbeing.

Whole Systems Approach to being more active

We are taking a Whole Systems Approach to developing our Physical Activity Ambition and Social Movement. We are following World Health Organisation guidance and focusing on four main strategic areas: create an active city, create active environments, create active people and create active systems.

The ultimate ambition is to develop a whole city (or system) approach, designed to make it easy for people to be active in Leeds.

[Editor notes: insert case study example]

'Home First'

Everyone who supports people in Leeds with planned or unplanned care will consider the option for them to stay at home wherever possible. People are 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) as soon as it is safe to do so.

People with needs associated with their learning disability, autism or Mental Health will be supported to live in their own homes wherever possible and stays in hospital are short and relevant to their health.

Staying in hospital longer than necessary can have a negative impact on a person's health – which is why thinking 'home first' is so important'.

Hospital stays will be as short as possible through making sure that links between the person and the people who work with them in their community are maintained throughout their hospital experience

Using our Leeds £ Wisely

We will work together across health, care and community organisations to focus resources and prioritise those areas where we can make the biggest difference in reducing health inequalities and improving life chances of our communities.

We will also use our collective buying power and resources to leverage social value, get the best value for our Leeds £, to enable a sustainable, high quality health and social care system fit for the next generation.

We have traditionally spent a lot of money on providing care in our hospitals rather than in our communities where people live. We want to re-distribute this money to both services and community initiatives that focus on prevention, self-management and proactive care in the community.

Making the Leeds Left Shift real

[Editor notes: ensure that the following has a clear definition of the Leeds Left Shift system change at the heart of it – elevator pitch definition]

Our ambition for Leeds to be the best city for all ages doesn't mean we want to be the biggest or the richest city, but best for quality of life. We continue to face significant and unacceptable health inequalities between different communities and groups in Leeds. Whilst we have made improvements, we know we have more to do, and need to think more innovatively to tackle the causes as well as the effects of inequity, inequality, and injustice. Decisions we take with people now must consider the impact on our future generations.

A relentless focus on reducing these inequalities will remain at the forefront of planning, delivery and evaluation of health and care services over the coming years. This means working with people every step of the way, listening to the voices of those who experience inequality, and using the strengths of communities, services and our wider partnerships to respond accordingly.

We know that in 10 years' time, the way our health services work will have to evolve and transform in response to economic, societal and technological advances.

- The rapid developments in genomics mean that people will have far more knowledge about their own health for the future, and many people will no doubt want to take far more proactive steps to protect their health.
- The role of technology in both supporting people to stay well and changing the way services are delivered is accelerating all the time.
- And as society changes, and people's expectations change in terms of how they work and how they interact with all service industries, the health system needs to reflect this in order to best respond to needs and secure on-going sustainability.

So we know that we need a new model of care for the city, with a real 'left shift' in emphasis and delivery.

'Building the Leeds Way' is our hugely ambitious programme to transform the hospital estate in the city centre. We are setting out to invest £xm in world class facilities at the Leeds Children's Hospital and Leeds General Infirmary, which in turn supports our strategy to deliver a left shift in healthcare and deliver key quality and outcome improvements. The new hospitals will be digital by design supporting the transformation of outpatient services and a 30% reduction in face to face attendances.

New day case and ambulatory care facilities will ensure the right care in the right place at the right time. Critical care and theatre capacity will be increased to ensure people can access specialist services such as spinal surgery in a timely way. Maternity and neonatology will be centralised increasing clinical productivity and the resilience of the service. A new midwifery led unit will be established increasing choice for women. The Leeds Children's Hospital will be a truly child friendly environment as is fitting in our child friendly city. The historic buildings which are no longer fit for healthcare purposes will be redeveloped, releasing 155000m2 poor quality estate and reducing backlog maintenance by

£100m. Instead buildings will be repurposed to contribute to the health and life sciences innovation economy a landmark regeneration project in the heart of the city centre.

Overall the scheme will deliver economic benefits of over £1.2bn and enable a further £2bn economic benefit by supporting the future renewal of the Leeds inner ring road. Building the Leeds Way is a once in a generation opportunity to provide state of the art healthcare facilities and catalyse economic growth for the city and wider region.

However, in order for it to be successful, we know that we need to do all we can to support people to stay healthy and to offer proactive services in the community which support people to stay well and offer the best care when ill and dying.

So in 5 years' time and in advance of our new hospitals, our exciting new community model and approach needs to be in place to create the transformed system -

[Editor notes: insert diagram representing the future service model at a high level e.g. Canterbury NZ style diagram]

To make this shift, we are committed to investing proportionately more of our resources in prevention, primary and community services, whilst still ensuring that hospital services are funded to deliver first class care.

This will result in more people in this workforce, significant improvements to our community estate and on-going exploitation of technologies for people to engage in health in health services. And above all, it will require a new relationship between all organisations to work in partnership together and with local people to reshape services to improve health outcomes.

Partnership focus

To be successful as a system in achieving the Leeds Left Shift we have agreed to give a number of areas extra attention as a partnership. These are:

1. Promoting good health	2. People at the centre of their care	3. Connected care closer to home

[Editor notes: need to include key areas of focus from the current 'enablers']

Each of the areas of focus are described in the following way.

Area of focus

Goal:
- A description of what this focus of area is aiming to achieve.

Building on continuous improvement:
- An overview of some of the specific actions we have already committed to undertaking as a partnership and will be successfully delivered in the short-term.

Transformational priorities:
- A few key areas of work that we have committed to undertaking as a partnership which will be delivered over a number of years. Some of these areas are currently in design / testing / development in parts of the city and the aim is to strengthen, deepen and widen their delivery across the whole of Leeds.

For each transformational activity there is a description covering:
- What is it?
- Who is involved?
- What does it mean for people living in Leeds?
- What is the change?
- How will it help to reduce health inequalities?

Case study
- An example of what good looks like once we achieve the goals.

Promoting good health

Goal:

In 3 – 5 years' time, our goal is that…

- People will experience a fundamental shift in focus from treating illness in isolation to promoting physical and mental wellbeing as an integral element of their care.

- Health and care services will place greater attention on:

  - Addressing lifestyle factors that contribute to ill health
  - Supporting people who live healthy lives to 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; and
  - Ensuring our future generations are born healthy and enjoy longer healthy life expectancy as the norm.

- The health and care workforce see prevention as central to our role and everyone in the workforce understands understand how they can support people to stay mentally and physically healthy and well.

- We use every appropriate opportunity, to applaud healthy lifestyle choices and to inspire and support positive behaviour change. This relates to life-style factors such as smoking, diet, alcohol and physical activity in addition to mental health and wellbeing and the wider determinants of health such as housing and employment

- The spaces and places where services are delivered and we work from provide green space, promote active travel and mitigate against air pollution.

Building on continuous improvement:

To achieve our goals we will:

- reduce the harmful effects that air quality has on our health in Leeds through taking focused action to reduce pollution. This includes identifying the contribution the Health and Care system can make towards this through changing how we operate and raising awareness of how to minimise exposure to polluted air

- encourage communities to build connections with people in their area so they can take action on the things that are important to them through continuing to implement our Asset Based Community Development (ABCD) approach

- ensure a Best Start for all children by promoting good maternal health (including mental health) and providing healthy living support throughout pregnancy and to new parents.

- protect the effectiveness of antibiotics through raising awareness of the risks if they are 'over used' amongst health and care professionals, primary schools and communities highlighting the most effective ways to treat infections.

- build on the success the city has had in reducing rates of obesity amongst reception age children, particularly in our more deprived areas, through developing a similar innovative programme for children aged 5 – 11.

- support and sustain longer term behaviour change by the provision of healthy living services, activities and assets which work in a more joined up way.

- avoid adverse child experiences and support families to stay together through taking a think family approach within all our services that tackle substance misuse, domestic violence and mental ill heath to minimise the impact that these factors can have on a child's life course.

- invest in early intervention and prevention mental health services to support children and Young People. We will do this through working more closely with schools through our Mental Health Support Teams and make information to support them more accessible, building on the success of MindMate

- improve access to and the quality of mental health services for adults, so support can be accessed when people need it t and prevent their needs from escalating. One way we are doing this is through providing a new primary care mental health service

- focus on the early identification of health conditions, particularly amongst our most deprived communities, to contribute towards reducing the years of life lost, particularly through accessible screening, raising awareness of symptoms and encouraging take up of health checks.

Transformational priorities:

- **Moving more – a city wide social movement – Get Set Leeds**
- **Building prevention into everything we do**

Moving more – a city wide social movement – Get Set Leeds

What is it? Get Set Leeds is a conversational approach that provides an opportunity for people to share ideas on what getting active means to them and what changes in the city might get them moving more. We want Leeds to be the most active city in the UK – because it's good for individual health and wellbeing, good for communities and good for the city as a whole.
We are determined to create an active city, with active environments and active people supported by active systems. Get Set Leeds aims to embed physical activity into everyday life and make it the most cost effective and easiest first choice in every community.

What does it mean for people living in Leeds? People are more likely to be active as leading an active lifestyle will be seen as 'normal' and become part of everybody's

everyday routine. What this means will be determined by the people of Leeds through a city wide conversation, Get Set Leeds. Following on from this conversation, the solutions will be jointly created and produced with the people of Leeds and every partner within the system.

What is the change? Being more active can have a significant impact on all aspects people's wellbeing. It has the potential to improve the physical and mental health and wellbeing of individuals, families, communities and the city as a whole. Evidence shows that regular physical activity reduces your risk of a range of health conditions including dementia, hip fractures, depression, cardiovascular disease, type 2 diabetes, colon cancer and breast cancer. Even when people have a health condition physical activity can reduce their reliance on medication and risk of complications.
The benefits of this initiative will even go beyond the Health and Care system with the potential to have a positive impact on promoting inclusive growth and tackling climate change.
The benefits of this initiative will even go beyond the Health and Care system with the potential to have a positive impact on promoting inclusive growth and tackling climate change.

Who is involved? Delivering the programme of work successfully will mean all partners working together, not only in health and care but wider local authority services such as planning, education, and the private sector particularly through anchor institutions.

How will it help to reduce health inequalities? Although this is a city wide transformational journey, the approach recognises the need and is committed to reducing inequality through working closely with the population groups that are the most inactive which include people living in our priority communities, children and families and people with learning disabilities or may have a long-term condition or disability.

Building prevention into everything we do

What is it? The aim is to activate all staff and organisations working within and supporting the health and care system around the prevention agenda. This would mean that every health and care professional:

- Understands their role and responsibility in supporting people to live a healthy lifestyle
- Routinely delivers healthy living brief advice and actively refers people into healthy living services when that is the right thing to do
- Has the opportunity to undertake training to support them in doing this

What does it mean for people living in Leeds? This means that people will be treated as a whole person and receive consistency with messages and services from their health and care services, working with individuals to understand the right treatment and service for them. This consistency will be received regardless of the service that they access.

What is the change? Energising the 70,000 health, care and support professionals in Leeds around this would have a huge impact on the health of the city and a significant impact in us achieving the Leeds Left Shift. At the moment in Leeds more than 50% of deaths are as a consequence of a health condition related to the way we live our lives. This could be prevented by routinely addressing the risk factors that result in ill health; however, this needs to be delivered at scale in order to have a significant impact on the

population's health and wellbeing. Through reducing smoking, alcohol, physical inactivity, poor diet and "stressful living" the conditions that could be avoided include cancer, type 2 diabetes, heart disease, stroke, hypertension, respiratory disease, depression.

Who is involved? The aim is that every health and care professional in every health and care focused organisation in Leeds is involved, in both the statutory and the Community and Voluntary sector.

How will it help to reduce health inequalities? Although making every contact count will benefit everyone city wide, the focus will be on reducing health inequalities by allocating resources and developing approaches alongside those people who most need the support. This includes: children and adults who may be experiencing higher levels of deprivation, pregnant women and their families, those that are at greater risk of long-term conditions, people living with mental illness and people with a learning disability.

Case study

Liz's journey towards improving her physical and mental health

After a traumatic accident which left her hip shattered, Liz was told she may never get back to being fully active.

But five years on, following three months of bed rest and even longer using a wheelchair and walking sticks, Liz is fitter and more active than ever.

"*Because I had to have a hip reconstruction and a lower pelvis break, I was in bed for a long time. It did have an impact on my confidence and my mood. At first it was really difficult to get moving, but once I was able to be active again, I felt the difference straight away.*

Walking and running became really important to me. I became an ambassador for 'Leeds Girls Can' and now I run walking and running groups for other women. It's really important to offer women-only groups because that enables women from all cultures to join in, and I've met so many interesting people.

It's especially important for women of my age to be active. It's just so good for you! It protects against getting ill, and it gets you out and about and meeting people. Being active was such an important part of recovering from my accident. Now it's just part of my everyday life, and I feel so much better for it."

People at the centre of their care

Goal:

In 3 – 5 years time,our goal is that…

- People feel that services work with them as an equal partner in their health and care, and see them as a whole person – this means their physical, emotional, and mental health are all considered in the context of their family and social connections.
- People also feel that services are focused on supporting them to be well and independent for as long as possible, promoting additional years of healthy life expectancy.
- People, families and carers have the skills and confidence to manage their own conditions including mental health conditions.
- Health and care professionals have received the appropriate training so they have the skills and confidence to support them in doing so.
- By building on their strengths, people will have more choice and control over how they manage their condition, ensuring their health and wellbeing needs are met in a way that works for them.
- We know if the person is a parent so the needs of the wider family can also be considered in conversations, taking a 'Think Family approach.
- Care is proactive. This means that:
  - People at risk of developing a Long Term Condition are supported to stay well.
  - People who already have a Long Term Condition are proactively supported by local teams and understand how to manage their health, to live as healthy and well as possible, and to maintain their independence.
- To support this, our health and care system has an in depth understanding of the local populations and proactively invites people to attend health checks and screening to identify and prevent ill health.
- Personalised Care and Proactive Care are embedded into every relevant pathway across Leeds. This is a fundamental role of our Local Care Partnerships (LCPs), which will allow us to work as a single team, within and with communities, targeting our efforts so that the poorest improve their health the fastest.

Building on continuous improvement:

To achieve our goals we will:

- ensure there is a range of support for people with long term conditions so they can access support in a way that works for them. This includes peer support, one to one support, structured education and digital solutions.
- work towards everyone receiving the same approach to their care, so their care journey feels consistent no matter which health or care organisation they go to through continuing to roll out the Better Conversations approach across our health and care workforce

- improve the lives and experiences of people living with frailty and their carers. We will focus on things that matter to people such as being active, socially connected and maximise the time spent at home.
- help people to stay well through offering annual health checks. There will be a focus on encouraging people with learning disabilities, autism and severe mental illness in accepting this offer as these groups are amongst those that experience the worst health inequalities.
- focus on the early identification of health conditions, particularly amongst our most deprived communities, to contribute towards reducing the years of life lost, particularly through accessible screening, raising awareness of symptoms and encouraging take up of health checks.
- respect peoples end of life wishes support them to die in the place they would want to wherever possible, both for adults and Children with life limiting conditions, through asking people what their preferences are and supporting our health and care workforce in having the skills and confidence to do this.

Transformational priorities:

- **Universal personalised care / strength and asset based person centred care**

Universal personalised care / strength and asset based person centred care

[Editor notes: need to incorporate the strength/asset based approach part into the below]

What is it? The aim is to move towards an approach to health and care that means people have the same choice and control over their mental and physical health that they have come to expect in every other part of their life.

What does it mean for people living in Leeds? People will start to feel a shift in their relationship with health and care professionals. They should increasingly feel their care is being planned around what matters to them, that they have choice and control in how their needs are being met and that they are an active partner in conversations about their health and care. This should be felt by everyone from maternity to childhood through to older age and end of life.

What is the change? There are six ways in which the model is being implemented. None of the elements are new, they have all been implemented in pockets across they system for many years. The difference is that through taking a system wide approach to implementation, the model will have a greater impact and people should experience a more consistent journey of care.

The six elements are:

1. **Shared decision making** - people are supported to make decisions about their health and care that are right for them in collaboration with health and care professionals

2. **Personalised care and support planning** – everyone with a long term condition will have a Collaborative Care and Support Plan (CCSP) that identifies what is important to them and ensures the support they receive is designed and coordinated around this

3. **Enabling choice** – people are provided with the support and information they need on the options that are available to them to shape their care and to help them make informed decisions

4. **Social prescribing and community based support** – people are referred to a Link Worker or Wellbeing Coordinator with a good knowledge of the local area. Once the worker understands what is important to the person they connect them to community groups and other services for support. Our ambition is for there to be over 5,500 people supported each year through social prescribing in Leeds.

5. **Supported self-management** – describes the range of options and approaches that are available to support people to manage their own care. This includes supporting education programmes that provide advice on how people can manage their own conditions and peer support where people are connected with people facing similar challenges, either face to face or electronically to provide mutual support in managing their condition.

6. **Personal health budgets** – is an amount of money somebody is given to support their health and wellbeing needs in a way that meets their needs. This isn't new money, but a different way of spending funding to meet the needs of an individual.

Who is involved? All health and care partners are be involved in delivering personalised care. The voluntary and Community Sector and the many assets in our communities will play a pivotal role in achieving this.

How will it help to reduce health inequalities? Through making sure health and wellbeing needs are being planned around the individual needs of the person and recognising that everyone has a unique set of skills, strengths and attributes, the personalised care model has played and will continue to play an important role in reducing health inequalities.

Case study

George's story of social support in his local community

Breathe Easy is a project that aims to develop an integrated network of respiratory peer support groups in Leeds to support people to manage their own condition. George, 82, was referred to the Harehills group.

"*On New Year's Day 2018 I nearly passed out and thought I was having a heart attack. After a visit to the doctors, a Spirometry test that wouldn't even register and a few other tests I was diagnosed with COPD.*

Since I joined Breathe Easy Classes in July I have found such a difference. Gradual slopes still get me, but I can walk further, and I push myself.

When I revisited the nurse for a Spirometer test in September I blew out at a force of 99. I was so shocked with the change! I will keep going.

The classes have really made a difference. We have a laugh and it's quite sociable and we always have a cuppa after with the instructor"

Connected care closer to home

Goal:

In 3 – 5 years time,our goal is that…

- People interact with health, care and community services nearer to where they live and however best meets needs. The variety of options will include third sector and peer support where they demonstrate efficacy and value.
- Accessing health and care services is easier for people and feels more 'joined up', meaning people have their health and care needs met through fewer interactions and only need to tell their story once.
- This shift to increased care in the community is fundamentally underpinned by our Local Care Partnerships (LCPs). Primary Care Networks (PCNs), will be a key contributor to LCPs, through providing GP practices with additional resources to develop community services.
- People only go to hospital when they need it, with hospital care used for acute, time-limited medical or mental health interventions. The number of visits people need to make to hospital before and after treatment are also reduced.
- Health and care professionals in the hospital work closely with health and care professionals in the LCPs and are seen as being an integral part of the wider LCP team bringing skill and clinical knowledge into communities. This may be through increased virtual consultation, more local clinics or through mature community based virtual ward arrangements for key conditions.
- When people need to access health and care services in an unplanned way they know where to go as there is a 'single point of access' to support people to make sure they receive the right care, in the best place at the right time
- Reducing the length of time people stay in hospital will mean that they can return to their homes sooner, with people supported to leave hospital for home, or an appropriate setting as soon as it is safe to do so.

Building on continuous improvement:

To achieve our goals we will…

- support Children and families to access the right care, in the right place, at the right time. We will further develop and implement our new Child and Family health and wellbeing hubs, alongside Local Care Partnerships which will support more health and care needs being met in the community and reduce the need for unnecessary hospital appointments
- improve the way in which we provide care for children, young people and adults with mental health conditions by increasing provision within our community and reducing the number of people sent outside Leeds for treatment
  improve the lives and experiences of people living with frailty and their carers. We will focus on things that matter to people such as being active, socially connected and maximise the time spent at home.
- provide medicines management support to community teams through Primary Care networks to ensure money spent on medicines management is evidence based, clinically appropriate

- work with health professionals to reduce the number of times people have to come into hospital, particularly for Outpatients appointments through using alternative clinic types such as video consultation, providing more advice to the persons GP so their care can be managed in the community or using technology for a more rapid assessment. An example of this is our tele dermatology service.
- provide information to people on how to access the right urgent healthcare for themselves with the aim of reaching a Single Point of Access. This will support people and professionals to make good choices from a comprehensive range of high quality services.
- support people with learning disabilities and autism to live well in the community in a number of ways including dedicated teams helping people to remain independent in their own home
- support the move of more urgent care needs being met in a community based setting. One example of this is through Urgent Treatment Centres that offer urgent primary care for minor injury and minor illnesses.
- support people with dementia to live independently in their own home (including a care home) through increasing access to diagnosis and specialist support, offering more support in the community for example memory café's led by the community and voluntary sector and a carers support service.
- Reduce the number of people with complex dementia needs in hospital through increasing the Leeds community bed base for this group of patients. We will also continue to commission enhanced care home support working with these patients and commission/fund bespoke placements as needed.

Transformational priorities:

- **Local Care Partnerships**

Local Care Partnerships

What is it? Local Care Partnerships (LCPs) form the basis of locally integrated health, wellbeing and care, rooted in communities. Much of the activity as outlined in this plan will be delivered through LCPs. They will use a 'bottom up' approach to improving health, wellbeing and care with a focus on priorities for their community such as a better response to people living with frailty. They bring together the full range of a community's assets to design and deliver integrated care that best meets the needs of the local population.
Primary Care Networks (PCNs), will be a key contributor to LCPs, through providing GP practices with the resources to develop community services.

Who is involved?

LCPs are locally based health and care teams that work together, with local people at their centre and led by those who work in those communities. They bring people together who have an influence on wider determinants of health.
This includes housing and planning, employment, care homes, social care, Third sector organisations, schools, police, fire service and elected members.

PCNs describe how GP practices will come together to provide a wider range of services by working with community healthcare services.

What does it mean for people living in Leeds? People will feel that they are at the centre of a locally based health and care team that helps them sort out the issues that matter to them most. Through a range of teams working together they should also start to feel their care is more joined up. For some people this should mean they have to attend fewer health and care appointments.

What is the change? LCPs are community driven and put people and partnerships at the centre of how care models are designed, delivered and evaluated. Each will have strong leadership teams in place that are inclusive and representative of the statutory, voluntary and independent sectors.

Their key features are:

- They are based on local areas and communities that have similar needs, recognising local diversity
- Services offered in locality include: General Practice, the full breadth of Primary Care (for example Physio and Occupational Therapists and mental health support), community services, council services and services offered by the community and voluntary sector.
- They are accountable for the health and wellbeing of their population
- The services offered evolve and respond to local need over time

How will it help to reduce health inequalities? LCPs will support a reduction in health inequalities through responding to local need rather than taking a 'one size fits all' approach to delivering health and care. Each LCP will work with people in their area to understand what is important to them and will be focused on organising the health and care services for their population around delivering these population outcomes. To achieve this resource will need to be directed towards the people who need it the most.

Case study

Working together to put people at the centre of their care *[Editorial note: Better title needed]*

Frank is in his 90s and living in care home. He has severe frailty and dementia. He also has Diabetes which had been difficult to control and as a result of this has been in and out

of hospital. His main carer, his Niece, was concerned about him going in and out of hospital, and felt powerless in terms of supporting her uncle and was concerned he would die in hospital which was not what he wanted to happen.
A data led approach focused on people with severe frailty, dementia and living in a care home. Through his Local Care Partnership a multi-disciplinary team was brought together within the care home. This included his carer and people who looked after him in the care home. A conversation about what mattered most to Frank was the starting point in planning his care. Together Frank's wish to avoid hospital where possible and work together was discussed and a joint care plan was pulled together to try and prevent this from happening.
This meant:
His care was predominantly in the Care Home minimising trips to hospital
He has an end of life care plan in place so everyone involved in Frank's care understands his wishes
His Niece works alongside other health and care professionals to plan Frank's care together
One of the health and care professionals involved said key making the difference was that "*We had the right people, sharing the right information, focused on the right patients and what mattered most to them".*

What will help us to get there?

Our ambitious vision of the Leeds Left Shift will mean a fundamental change in the way health and care is delivered. A change in the relationship between people and health and care professionals. And a fundamental change in how we think about health and care services. Innovation and experimentation will be crucial to make sure we don't go back to delivering health and care services in 'the way we have always done'.

The foundation to achieving our ambition will be our 'enablers' of change, delivering system wide solutions that not only support our new way of working but also lead the way in setting out innovative solutions to take our ambition and aspiration further faster.

[Editor notes: the following enabler descriptions to be written up into similar tables to that used for previous section]

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Workforce

Goal:

In 3 – 5 years' time, our goal is that…

We will work as if we are 'one' team, growing our own workforce from our diverse communities, supported by leading and innovative workforce education, training and technology with the Leeds Health and Care Academy key to the delivery model.

Building on continuous improvement:

To achieve our goals we **have developed 4 shared workforce priorities as follows:**

1. **Improving Employment (Attracting and retaining our current and future workforce) -** We will provide opportunities for skills, jobs and wealth creation, engaging and recruiting those in our most disadvantaged communities and inspiring the next generation health and care workforce. This will ensure we have the highly diverse, skilled workforce we need to serve the people of Leeds, now and in the future.
2. **Improving working lives -** We will improve workforce mobility, making sure Leeds is the place to work in health and care. We will improve access to the highest quality education, support and development for our current and future workforce. We will recognise the importance and impact of mental health alongside physical health. We will support women in the workplace being a voice for increased visibility and connections across organisational boundaries.
3. **Improving systems working (across organisational boundaries) -** We will foster a citywide culture where the health and care workforce operates as if it is one team - "one Leeds workforce". Our people will work, learn and develop together in new ways, enhancing career opportunities and providing a more seamless experience for citizens and patients.
4. **Improving working partnerships -** We will work with health and care organisations across the city to enhance collaboration when bidding for new and additional funding and, through this, to respond to the city's strategic workforce priorities. We will establish the city strategic workforce collaboration across employers, representative groups and trade unions to strengthen the workforce and citizen voice in our work. We will support the creation of Leeds health and care employer's hub.

Transformational priorities:

- **Transform Primary Care by working with communities**

- **Improve nursing recruitment and retention**

Transform Primary Care by working with communities

What is it?

Support new ways of working and recruitments for new posts funded through new GP Contract (Clinical Pharmacists, Social Prescribing Link Worker, First Contact Physiotherapist, Physician Associate, First Contact Community Paramedic)
Supporting the resourcing of staff for the additional roles for example co-developing consistent job descriptions and advertising at scale.

What does it mean for people living in Leeds?

Higher quality of health and care services being delivered more effectively and efficiently through Local Care Partnerships.

What is the change?

New roles and services delivering health and care in communities to enable faster and more effective service delivery.

Who is involved?

All health and care services.
LCPs bring people together who have an influence on wider determinants of health. This includes housing and planning, employment, care homes, social care, Third sector organisations, schools, police, fire service and elected members.

How will it help to reduce health inequalities?

Local Care Partnerships working within the communities they serve and can target resources to work with their population and local community stakeholders to provide holistic solutions to specifically address the heath inequalities within the locality,

Improve nursing recruitment and retention

What is it?

Joint approach to Nursing recruitment, jointly attending nursing recruitment events- presenting as “one Leeds system”.

Targeted local recruitment events in priority neighbourhoods- first event identified 3 Nurses with overseas qualifications.

General Practice Nursing Strategy developed in partnership with the Leeds GP Confederation to address the workforce challenges we have in terms of Practice Nursing; outlines approaches in relation to recruitment and retention, developing better career paths/structures as well as new roles

What does it mean for people living in Leeds?

We are working closely with our social care colleagues to support care homes in the city by helping them to attract more people into careers in nursing in care homes

This in turn will help in improving the quality of nursing practice in care homes through improving capability, reducing vacancies so increasing capacity.

What is the change?

Collaboration to improve recruitment and retention across the Leeds health and care system.

Who is involved?

All health and care services, specifically nursing professionals.

How will it help to reduce health inequalities?

Creating employment opportunities within local priority neighbourhoods through the wider determinants of health.

Case study

Leeds Teaching Hospital NHS Trust recruitment event helps people from Lincoln Green into employment

Lincoln Green is a Leeds neighbourhood facing some of the most significant challenges in terms of low income, unemployment, health deprivation and poor living environment. It is home to St James' Hospital, one of the largest teaching hospitals in Europe. Although employing over 18,000 people, there are a number of vacancies at any one time, ranging from grounds staff, housekeeping, healthcare assistants, and of course nursing.

Leeds Teaching Hospital NHS Trust and Leeds City Council recently held a recruitment event aimed at people who live in Lincoln Green, helping connect them with job opportunities at the hospital.

As a direct result of the event, attended by over 130 people, 28 people have now secured jobs in LTHT in nursing, clinical support, catering and grounds maintenance.

In addition, through recruiting from the local area that has a rich and diverse migrant population, it was possible to connect with local residents with overseas medical qualifications, including refugee doctors and nurses from Syria and Afghanistan, working with them to convert qualifications and join our health and care workforce.

All parties hope the success of this single event can be transformational – both for the individuals who secured jobs, as well as for the wider local community. Following the success of the event, health and care partners have committed to hosting further events across the city, so that we can continue to support people living in poorer communities into work.

This project is an excellent example of the strengthening relationship between health and care, and the wider determinants of health; linking together health and wellbeing priorities and the city's inclusive growth priorities.

Estates

Goal:

In 3 – 5 years' time, our goal is that…

Through strategic investment, our estate will be transforming into space fit for 21st century health & care services, where design and delivery are results of co-production with our communities and system partnership.

Building on continuous improvement:

To achieve our goals we **have developed 6 principles to underpin all strategic estates consideration and decision making:**

5. **Community**
   - Supporting those most in need
   - Working with communities to be healthier places
6. **Condition**
   - Deliver estates which positively reflect the value of our citizens & staff
   - Prioritise action on the worst first
7. **Culture**
   - Support new ways of working – digitally enabled and connected
   - Think 'system' – multi-use buildings as default
8. **Capacity**
   - Use better what we have
   - Plan for the future, aligning service demand & workforce
9. **Cost**
   - Charge once to the system (Leeds £)
   - Proportional risk sharing
10. **Climate**
    - Increasing energy efficiency across the estate
    - Using our estate to actively minimise vehicle journeys

Transformational priorities:

- **Health & Planning**

Health & Planning

What is it?

A piece of work aimed at achieving greater collaboration between the city's Local Planning Authority and 'health', so that through both Planning's functions of strategy/policy and development management (processing of planning

applications) consideration of health and wellbeing of our communities forms a core aspect.

What does it mean for people living in Leeds?

It means that:

- Future new developments (housing and commercial) promote health & well-being through better spatial design e.g. creating usable greenspace, giving pedestrians and cyclists priority rather than cars; and
- The sustainability (capacity and quality) of primary care services are protected from negative impact of housing growth, as both a direct and cumulative effect of developments within communities.

What is the change?

Through, and with the Local Planning Authority health and care commissioners and providers will work collaboratively to safeguard health services from increased demand due to housing growth. Mechanisms for achieving this include opportunities to leverage funding from developers to create new, or extend existing health and care infrastructure, where currently there is no mechanism.

Working with developers to influence spatial planning of new developments, which may mean less housing units are achieved but another kind of value is added through promotion of health and well-being for residents.

Who is involved?

- Local Planning Authority
- Public Health
- Health Partnerships (Estates)
- Elected Members (Executive Members and Scrutiny)
- Health commissioners
- Health providers

How will it help to reduce health inequalities?

By ensuring that health service capacity and quality is safeguarded from any adverse effects of increased population size as a result of housing growth. Also through influencing spatial design to promote health & wellbeing residents within, and around new developments will live healthier, more active lives.

Case study

Burmantofts Health Centre

Lincoln Green is one of six priority neighbourhoods agreed by the Council where a new place-based approach to service delivery, tackling poverty and reducing inequalities in our poorest neighbourhoods has been adopted. The new approach seeks to prioritise the city's collective endeavour and resource, work closely with communities so that things are done with, not to them, and enable a cultural change across partnerships.

Burmantofts Health Centre, owned by Leeds Community Health Trust, sits within the Lincoln Green priority neighbourhood, adjacent to the district centre. The centre is currently occupied by 2 GP surgeries, a sexual health clinic, as well as other limited community health services. The building is both under-utilised and in need for significant investment, or ideally redevelopment to bring it up to the standards of a modern, 21st century health facility.

In-principle agreement has been given by Leeds Community Health Trust to the redevelopment of the health centre site, a proposal which has been identified as the preferred option in an Option Appraisal commissioned by the city's Strategic Estates Group. The redevelopment opportunity has garnered interest from the Council's Communities directorate, who have expressed an interest in creating a new Community Hub in Lincoln Green, as part of any new building health facility.

Further to initial consideration of the redevelopment opportunity being a standalone project, discussion, through the priority neighbourhood programme, has opened up the possibility of it forming part of a wider regeneration of a number of key sites in Lincoln Green. As a result a partnership piece of work is underway between Regeneration, Communities and Health Partnerships (estates) to explore options for regenerating/redeveloping a commercial offer, new housing and a community/health centre within the area. The ambition is that this piece of work will result in an investment plan, to be submitted for approval to the Council's Executive Board in 2020, which seeks to:

- ***Help Lincoln Green transition from a gateway location to a settled, prosperous multi-cultural community where differences are respected, and the community is supported to develop and grow;***
- ***Improve the provision of housing and public spaces, in particular for young families and children;***
- ***Improve access to jobs and services, including local health and care facilities; and***
- ***Improve the physical environment to make it more healthy, enjoyable and relevant to the future needs of the local community.***

Communications and engagement

Goal:

In 3 – 5 years' time, our goals are…

- To work in partnership with local people, so that their voices are at the heart of everything we do. This means we start with people, design with people, work with people, and evaluate with people.
- To motivate people to make healthy lifestyle choices for themselves and their family.
- People know the best ways to self-manage their conditions, and that when they need to access health and care services, they know which services are available to best meet their needs.
- To use our communications and engagement to target people and communities that are experiencing the biggest health inequalities.

Building on continuous improvement:

To achieve our goals we will:

- Build on the success of the inaugural Big Leeds Chat (BLC) event in 2018, we will develop BLC as an annual series of 'listening events' that connects local people with the people making decisions about health and care in Leeds, including in local communities.
- Work with people in priority communities to develop targeted campaigns that motivate them to make healthier choices - for themselves and their family. We will work in partnership to develop consistent messaging, make better use of the Leeds £, and strengthen our reach.
- Ensure local people easily understand how to access the best care in the best place at the best time.
- Champion plain English language in all of the ways that we communicate with local people, whether that be through the campaigns we deliver, the letters and emails we send, or the face-to-face conversations we have with people. Consider accessibility issues in every piece of printed and digital information we produce, ensuring we adhere to the Accessibility Information Standard.
- Collaborate on our engagement - through shared engagement activities, training and principles. We will target our priority communities through our collaborative engagement.
- Collaborate on workforce communication, to strengthen the flow of information between system leaders and the rest of the health and care workforce.
- Scope the potential for a 'people's panel' that all health and care partners can utilise to engage local people and put their voices at the centre of transformation.

- Scope the potential for a partnership engagement database and schedule, which will allow us to be better co-ordinate our consultation and engagement with people.
- Improve our understanding of what it feels like for people 'flowing' through the health and care system in Leeds, so that we can inform change and improvements.

Transformational priorities:

- **Working in partnership with people – collaborate and empower**
- **Collaborative targeted campaigns**

Working in partnership with people – collaborate and empower

What is it? We will work with local people at every stage our decision-making so that we can ensure we are meeting the needs of local people, whilst empowering them to better manage their health and wellbeing. We will particularly target people experiencing health inequalities, establishing trusting relationships that motivate people to work with us. Through our engagement we will strive to go to local people, collaborating with them within an environment they are comfortable with.

Who is involved? The People's Voices Group, which brings together engagement leads from across the city, will lead and support a culture of co-design across the city. They will develop strong and consistent principles to the way that we work with local people, and develop skills that enables all decision-makers to work with people.

What does it mean for people living in Leeds? People will want to work with us, and will know how to work with us, so that the health and care system meets their needs, and that of future generations.

What is the change? We will increase the level of influence that local people have.

How will it help to reduce health inequalities? We will strive to work with people and communities experiencing health inequalities, so that the changes we make will have the biggest positive impact on them.

Collaborative targeted campaigns

What is it? Campaigns play a crucial role in changing people's behaviours and perceptions. Partners have a proven record of delivering campaigns across the city. However, we are committed to improving the health of the poorest fastest, and effective targeted communications and engagement with residents in the poorest parts of the city can be enabler of this.

We will pool our skills and resources to deliver effective targeted campaigns in the city's priority neighbourhoods. Campaigns will be based on insight about the

people who live in these areas, what their health and care needs are, and on what their lifestyles are. This targeted insight-driven approach to campaigns will help in achieving our Leeds Left Shift in those poorest communities.

Campaigns will be developed specifically for these areas, and will be enabled through a four-step process:

- **Scoping and insight:** Research in these areas will help us understand the people who live in the communities, what the health and wellbeing issues are in these areas (for example their unhealthy lifestyles, the way they access services), and what assets are available to the people in those communities, and the different needs of the people who live them. This will enable us to develop interventions that will have the biggest impact.
- **Diagnosis and design:** Based on our robust evidence we will develop strategic recommendations and development of implementations. Co-production will form a key part of this process, and as such we will seek to engage, involve and empower our target audience.
- **Implementation:** This may mean changing the way services are delivered, or creating social marketing strategies, developing specific innovative interventions, including materials, social media platforms, peer networks and community influencers – this will depend upon the needs and wants of the audience.
- **Evaluation:** This will enable us to continuously improve the impact of interventions, to demonstrate social benefits and value for money. Evaluation will also enable us to put in place effective plans to scale up this approach beyond the six priority areas.

Our collaborative campaigns will focus on promoting good health, people at the centre of their care, care closer to home, and celebrating Leeds as the best city for health and wellbeing.

Who is involved? This work will be led by the City-wide Communications Network, which brings together communications leads from across the health and care system.

What does it mean for people living in Leeds? Campaigns developed using insight and co-designed with people, will improve the impact of the campaigns.

What is the change? Whilst communications teams across the system have a proven record of delivering campaigns, this new approach will see all partner organisations working together to develop and implement campaigns. Campaigns will be more targeted than ever, and will be co-designed with the people we are targeting.

How will it help reduce inequalities? We will target our campaigns towards communities and people who are most affected by health inequalities.

[A co-design case-study would probably be better than BLC]

Case study: Big Leeds Chat

The Big Leeds Chat (BLC) led by the People's Voice Group is a new way of listening to people in Leeds. It brings together senior decision makes in health and care, working together as one health and care team to talk to the people of Leeds about what matters them.

The BLC was first held in 2018, and was hosted in Leeds Kirkgate Market, where we spoke to around 500 local people. We will continue to develop the BLC as an approach for proactively engaging with local people, hosting events across the city.

The feedback from BLC continues to shape local services in Leeds, including the Leeds Health and Care Plan.

[Editor notes: following enabler descriptions to be written up into similar tables to that used for previous section]

Population Outcomes *'Our role is to make it easier for services to deliver in a more co-ordinated and joined up way through commissioning based on what matters to people rather than the number of people they see'*	We will: • Work with specific population groups in neighbourhoods to understand what good looks and feels like to them • Commission services in a way that sets the condition to them to achieve this
Digital *"Our role is to provide the infrastructure to develop connected services, support the shift in relationship between the person and the health and care professional and provide the support care closer to home – whilst raising the digital skills of the people of Leeds, so more people in communities can benefit from these innovations."*	We will: • Develop HELM, our person held record, to support people and their carers in interacting with the health and care system and managing their own health and well being • Support delivery of integrated services in the community and people only telling their story once by assisting the community and voluntary sector to use digital facilities health and care services have such as the Leeds Care Record. • Develop a single point for people to access information about health conditions to support people making informed decisions about their care • Continue to support people in building their digital skills through continuing to deliver our NHS Widening Digital Participation programme. • Through our Smart Cities programme we are aiming for all citizens to be digitally literate and for everyone to feel digitally included. We know that helping people to become digitally included will bring wider social benefits. Improved digital skills help people be better informed, pay less for things, be more employable, feel more independent, be less isolated, and live better, easier, longer lives.

Finance

"*Our role is to direct our collective resource towards the people, communities and groups who need it the most. This means re-distributing more money towards services focused on keeping people well and services in the community*"

Our transformational work will direct our collective resources towards improving outcomes for the people, communities and groups who will benefit the most. To support this, funding will need to be used more flexibly and creatively. Finance colleagues will support collective decision making, ensuring throughout it is underpinned by sound financial evaluation.

We will

- Maximise the impact of financial growth (where present) and develop flexible ways to fund services which align the incentives of funders and providers. The purpose will be to enable a 'left shift' of services towards community and preventative interventions. This will allow demand to be better met with care closer to home.
- Use population financial modelling ("actuarial analysis") to produce more accurate projections of the impact and trajectory of transformation / population based interventions on expenditure to ensure system sustainability.
- Create a shared understanding and collective agreement of the costs of health and care activity and use this as the partnership financial framework for health and care services.
- Reduce transactional costs and recharging and estates costs through joint working and shared approaches.
- Create a culture of collective working across system finance professionals to maximise the impact of the Leeds pound in leveraging social value, reduce health inequalities and improve the life chances of our communities.

How we will know we are achieving our Leeds Left Shift?

One of our partnership principles is 'we deliver'. The following describes how we will check, challenge and assure ourselves that our Plan is making the difference we have set out. There are four aspects that we will use to check ourselves. These are:

- Outcomes
- Indicators
- Performance measures
- People's experience.

Outcomes

In Leeds our culture is of seeking better conditions of wellbeing for people, or "outcomes". Our approach is outcomes focused. There are 5 outcomes in our Health and Wellbeing Strategy which we are seeking for people in Leeds as a whole. To complement the ones for the whole of Leeds we have specific outcomes for those groups of people with specific health and wellbeing needs, for example people living with frailty.

(Population) Outcomes

Are conditions of wellbeing for groups of people (defined populations). Example: "people (in Leeds) will live longer and have healthier lives"

Indicators

Indicators

A number which helps show (as a partnership) we are making progress towards an outcome. Example: "the number of hospital bed days per 100,000 population"

Indicators are numbers that help us understand if we are making progress towards outcomes for people. As a health and care system it is essential that we have timely indicators to understand the progress we are making and where we need to re-focus our resources, energy, and attention for greater impact. We will use this information to challenge ourselves to do things better and to do better things. This is what will help to keep our Leeds Plan 'live' and responsive.

Performance measures

We will use more detailed performance measures of our Leeds Plan programmes and services to understand the impact of our actions.

Performance measures

Measuring performance for a programme, project or service. This means considering how much we did? How well did we do it? And, did it have any impact? Example: "the number of people who felt their social prescribing service was effective"

Stories and people's experiences

Stories and experiences are an essential part of how we will know we are making a difference and provide a deep insight into how does it feel for people who use our services. We need to be assured that people's experiences are good. This is particularly true where their 'journey of care' means they use and move between a number of different services such as a GP, social worker and a hospital. We will document and share how people feel about their experiences of care. This will include in-depth feedback from individuals, highlighting the stories of care evident in people's case records and improved routes for people to give feedback. Findings from these exercises will be explored within our health and care partnership on a regular basis with recommendations for change, to support a constant cycle of quality improvement.

Stories and people's experiences

Being assured that people's experiences are good.

Example: "experience of the journey of care between different services"

Focused indicators or our "obsessions"

We will use a small number of 'bellwether' indicators to share widely to focus action and share progress. They have been chosen on the basis that if we make improvements here, then other positive changes will likely follow.

Obsession	Indicator	
Increase the health and care contribution to the prevention of ill health		Measuring of lifestyle activity in Primary Care including brief advice offered and onward referral to services e.g. smoking, weight management, physical activity and alcohol use
Increase the number of people who live well in their own homes and communities		Safely and appropriately reduce the number of hospital bed days utilised per 100,000 people
Improve the mental health of people living in Leeds		Reduced the number of people from Black, Asian and Minority Ethnic (BAME) backgrounds who are detained under the Mental Health Act

[Editorial note: The new MH Strategy is in development. The MH obsession and corresponding indicators may need to be revised accordingly]

How we will know if we are connecting with a wider agenda – our shared obsessions

We know everything is connected, and that whilst our obsessions serve to inform us how we are performing as a health and care system, to really improve and transform the health and wellbeing of people in Leeds we need an all-encompassing approach that considers not only health inequalities but inclusive growth and climate change alongside other factors that impact our health on a daily basis including community safety and the environment.

Obsession areas across other aspects to improve health and wellbeing are:

- Increasing the number of people with mental health problems accessing employment, training and education).
- Reducing the number of street homeless people in Leeds
- Safely and appropriately reducing the number of children looked after

[Editorial note: we will need to say more on these e.g. indicators etc]

Call to action

[Editorial note: the following needs strengthening considerably to become a call to action]

Our plan is only the start. The responsibility now sits with every single one of us to make this change happen. We are all empowered to do this. The time is now. And through working with our strong communities and harnessing the power of our partnerships and strong community and voluntary sector and consistently working beyond organisational boundaries we can improve the health and wellbeing of people in Leeds both now and for generations to come.

Our Leeds Health and Care Plan invites every single one of us, wherever we work, whatever our roles may be, to be a system leader. We already do what we do in order to make a difference. This is about viewing the bigger picture, working with people and partners, as if we are one organisation, which can make an even bigger impact. So if you're designing, delivering, or evaluating services, you will be playing an important role in making change happen. You have permission to do this, to think creatively, to work differently. In this way, you'll be building on our strong and successful history of delivering change in partnership. We have collectively learned that the key to working in this way is not 'what' you do but 'how' you do it.

Being a system leader

"I work beyond the boundaries of my own organisation to deliver the best health and wellbeing outcomes with the people of Leeds"

Appendix 1 - People's voices at the heart of the Leeds Plan

In Leeds we put the voices of local people at the heart of the future of health and care, and the views of local people have helped inform the refreshed Leeds Plan.

In writing the refreshed Leeds Health and Care Plan we used the key findings of some of our most recent engagement across the city, including the findings of the Big Leeds Chat event in 2018, engagement on the NHS Long Term Plan, and engagement as part of a 2019 scrutiny inquiry into whether Leeds is a child friendly city.

It should be noted the following summary does not aim to outline how we have used all of the engagement insight that we have collected in the city, but just the headline feedback that has impacted the Leeds Health and Care Plan. Insight we collect through our engagement continues to influence different strategies and services across the city, and where possible we aim to demonstrate how we have used the findings of engagement.

Promoting good health	
What people told us	**Our response**
More support is required from the NHS and its partners to make it easier and affordable for people to live healthier lives.	• Integrating prevention into all clinical pathways. • Our estates will provide green spaces, promote active travel and mitigate against air pollution. • Social prescribing services are connecting people to non-medical services and activities in their local area.
Barriers to improving lifestyle choices include a lack of time and motivation, and poor health.	• Better Conversations approach is helping local people use their strengths and assets to make healthy lifestyle changes. • The new physical activity ambition for the city is being co-produced by local people, and changing the conversation on what being active means. • Links in with the wider determinants of health through the Leeds Health and Wellbeing Strategy, and other city-strategies and boards including Inclusive Growth.
Supporting mothers during pregnancy, supporting families with new-born babies, early diagnosis of conditions and support through childhood.	• Best Start is a preventative programme from conception to age 2, aiming to ensure a good start for every baby, with early identification and targeted support for vulnerable families early in the life of the child. • Children's Hubs are bringing organisations together to improve the health and wellbeing of children and families, with more focussed support in areas of highest need. • Maternity Strategy - sets out city action for high quality, safe and personalised maternity services. • Children and Young Peoples Plan - our plan for Leeds to be the best city for Children and Young People to grow up in and to become a child friendly city. • Improved perinatal mental health provision through the Mental Health Strategy. • Think Family approach recognises the impact that adult mental health needs can have on children's health and wellbeing

Addressing street drinking, drugs and mental health.	• A new Leeds Drug and Alcohol Strategy has been launched. The new strategy has a number of priorities, including providing better health support for people misusing alcohol and drugs, and reducing crime and disorder as a result of misuse. The Leeds Alcohol and Drug Strategy will help achieve some of the priorities identified in the Leeds Health and Wellbeing Strategy.
Better promotion of activities in local communities.	• Social prescribing services are connecting people to non-medical services and activities in their local communities. • Building prevention into our clinical pathways will help health professionals to better signpost people to activities and services in their local communities. • Targeted communication campaigns, co-designed with local people, will strengthen the outcomes of our promotional activity. • A continued commitment to the Leeds Directory, which is used by local people and professionals, and promotes local activities and community groups.
More prevention of mental ill health.	• In our Health and Wellbeing Strategy, one of the key priorities is to promote good physical and mental health equally. This is reflected in our Plan goal of promoting good health, which includes mental health as well as physical health. • Connecting with the Best Start programme and the Future in Mind plan we recognise that getting it right for children benefits the whole population throughout the life course. • We address the wider determinants of mental health, specifically reducing risk factors and increasing protected factors, targeting communities with the poorest mental health through good accessible information, self-care, peer support and social prescribing. • Targeted support for people from BAME communities to reduce hospital admission for mental health issues.

People at the centre of their care

What people told us	Our response
People's additional needs and personal circumstances need to be taken account when accessing services.	• Our Better Conversations approach will enable health and care professionals to work with local people to help them better utilise their strengths and assets. • Implementation of personalisation will ensure people with long-term conditions or illnesses receive support that is tailored to their individual needs and wishes. • We are improving the lives of people living with frailty by taking a population outcomes approach and overseeing the implementation of an integrated model which has been developed by providers. This programme includes the implementation of virtual frailty wards across the city. • Our work on patient experiences will help us understand what it feels like to be a patient in our services, including for those with particular additional needs.

	• We will continue to use data and insight through our various satisfaction and complaints processes to inform service design.
Digital technologies have an important role to play, but digital services need to be better joined-up and easier to use, and we need to be mindful of digital inclusiveness.	• We continue to be committed to the Leeds Care Record, which enables health and care providers to link people's data, and provider better and safer services and advice. • HELM is the city's personal health record which is currently being developed. It will be tested with a small cohort of users, and developed in an iterative way to ensure it is easy for people use. • The city's Smart City approach is committed to achieving a 100% digitally enabled population. • The Leeds Repository will bring together health and care information onto one platform, meaning it will be easier for people and professionals to access. • Digital choices for appointments will be introduced, particularly for GP and outpatients appointments.
Patient-driven and patient-managed care, enabled by more empowered patients.	• Our Population Health Management approach means we will bring together health-related data to identify specific populations which will allow us to prioritise our services to meet their needs and deliver personalised services. • HELM is the city's personal health record which is currently being developed. This will give people greater access to credible health information, data and knowledge, meaning they can better improve their health and manage their health conditions. • Our Better Conversations approach enables health and care professionals to work with local people, to empower them to live healthier lives, and better manager their health conditions.
Data has an important role to play in our ambition to deliver more personalised care.	• Our Population Health Management approach means we will bring together health-related data to identify specific populations which will allow us to prioritise our services to meet their needs and deliver personalised services.
Children's mental health services need to be easier to access.	• Improving the social, emotional, mental health and wellbeing of children and young people is a priority of the Mental Health Strategy. • Think Family approach recognises the impact that adult mental health needs can have on children's health and wellbeing • One of the core passions of the Mental Health Strategy is to increase the numbers of people with mental health needs in education, training and employment

Connected care closer to home

What people told us	Our response
A wider range of professionals from the NHS, local authority,	• We will continue to implement the 18 Local Care Partnerships across Leeds, which bring together

private health and social care organisations, and the community and voluntary sector, working closer together to plan and deliver health and care services.	professionals from the health and care sector, third sector, and decision-makers who influence the wider determinants of health. LCPs will enable a more person-centred care model, closer to a person's home.
Access to GP surgeries and specialist services.	• Digital choices for appointments will be introduced, particularly for GP and outpatients appointments. • Specialist services will be a core part of the Local Care Partnerships, meaning these services can better accessed in communities. These services will be based on the needs of the local communities that the LCPs serve. • The Urgent Treatment Centres will provide specialist services for urgent care in communities. • We are developing new services in GP surgeries, such as Cancer screening, meaning people can access these services closer to home. • LCPs, UTCs, and new services in GP surgeries (e.g. cancer screening) will help improve waiting times at hospitals.
Health services to embrace digital technologies.	• Digital choices for appointments will be introduced, particularly for GP and outpatients appointments. • Online booking systems have been introduced at GP surgeries, and these will continue to be promoted. Online bookings will also be explored in other health settings.
More investment in community mental health services.	• As part of the Community Mental Health service redesign that is being implemented across the city, home-based treatments are being introduced where it is safe for them. • Developing more community based crisis support services. • Reduce of the numbers of people from BAME backgrounds who are detained under the Mental Health Act is a core obsession of the Plan. • IAPT services continue to provide valuable mental health services in local communities.
There are concerns that moving outpatient appointments into community settings could impact quality of service, this was particularly raised when engaging on cancer services.	• Services will be co-produced with people, so that they are person-centred. • Services implemented into communities will be subject to risk assessment, and only implemented when appropriate.
People find it confusing which services to use for unplanned care, for example whether to attend Minor Injury Units, A&E Departments, or Walk-In Centres.	• Five Urgent Treatment Centres will be introduced across the city. These will make it easier for people to know where to go for unplanned care. • In implementing the UTCs we will continue to engage with people using the services to better understand their experiences, which will help improve communication within the centres – for example through signage. • Robust referral pathways and communication mechanisms will be implemented, aligning the LCPs and PCNs to the UTCs.

[Editorial note: The following table will be presented as a graphic in the finalised version]

Children and Young Peoples Plan - our plan for Leeds to be the best city for Children and Young People to grow up in and to become a child friendly city.	***Leeds Mental Health Strategy*** - sets our ambition and plan to be a mentally healthy city for all ages.	***Autism Strategy*** - our actions for improving support and care for people living with autism.
System Resilience Plan - our actions to manage and improve hospital flow including improved urgent care and rapid response services.	***Frailty Vision –*** our vision and model for people living with Frailty in Leeds.	***Diabetes Strategy*** – sets out how as a system we will work together to deliver the best outcomes for people at risk of or living with Diabetes.
Maternity Strategy - sets out city action for high quality, safe and personalised maternity services.	***Age Friendly Leeds Strategy*** - sets out the strategic context and approach for Leeds to be the Best City to Grow Old in.	***Future In Mind Leeds: Local Transformation Plan*** **-** explains how people will work together, across the system to improve children and young people's emotional and mental health in the city, from birth up to age 25.
Best Start Plan - our broad preventative programme from conception to age 2, which aims to ensure a good start for every baby, with early identification and targeted support for vulnerable families early in the life of the child.	***Leeds Drug and Alcohol Strategy*** – our framework for how we work with individuals, families and communities to address drug and alcohol misuse.	***Leeds Digital Roadmap*** – our health and care digital vision for the city.
Learning Disabilities 'Being Me' Strategy - describes the things that we need to do together to improve the lives of people living with Learning Disabilities in Leeds.	***Leeds Carers Strategy*** - our approach to putting carers at the heart of everything we do.	**Dementia Strategy** - describes how we want Leeds and our local services to be for people living with dementia. This includes family members and other carers of people with dementia.
Citywide Workforce Strategy - describes the citywide strategic shift we need to make in capacity, capability and culture across the health and care workforce in Leeds.	***LAHP Strategic Framework*** - outlines the shared priorities for universities and the health and care system, to accelerate the adoption of research and new approaches to improve service outcomes, reduce inequalities and create Investment and jobs.	**Integrated Commissioning Framework** - outlines the mechanisms for supporting further integrated commissioning between the health and care, and the processes through which we will continue to develop this in the future.

Appendix 2 – Some of our system wide strategies and plans

The following is an outline of the key areas described in greater detail in the Leeds Health and Care Plan narrative document. An accessible/plain English plan on a page will be produced over the coming months – DRAFT V3 – 10/9/19

Leeds Health and Care Plan

- **Focuses transformation efforts to make significant and lasting change that reduces health inequalities and increases healthy life years for all ages, creating a healthy city with high quality services, where people who are the poorest improve their health the fastest.**
- **Contributes to achieving: 5 outcomes of our Health and Wellbeing Strategy and our place contribution to the West Yorkshire & Harrogate Integrated Care System.**
- **Created by our community health and care service providers, GPs, wider primary care, local authority, hospitals and commissioning organisations, citizens, carers, elected members, volunteer, community and faith sector and our workforce.**

"Everything is connected"
To be the best city we need to reduce health inequalities, promote inclusive growth and tackle climate change.

This is Leeds

- **A vibrant and diverse economy…but unequal. 170,000 of our 785 000 population live in areas where multiple economic, social and housing factors will (on average) lead to poorer health. More of our children and young people live or are born into these communities than in other cities.**
- **Partnership Principles: We Put People First; We Deliver; We Are Team Leeds.**
- **Culture and approaches – "Working with / Better Conversations", "Asset Based", "Home First", "Think Family" and "Using our Leeds £ Wisely".**

LEEDS LEFT SHIFT

Promoting good health

Goal: a shift in focus from treating illness in isolation to promoting physical and mental wellbeing as an integral element of all health and care

Building on continuous improvement: ↓ effects of air pollution; ↑ communities taking action through asset based approaches; ↑ health living throughout pregnancy; ↓ 'overuse' of antibiotics; ↓ obesity in childhood; ↑ services to improve behaviour change; ↓ adverse childhood experiences; ↑ investment in early intervention / prevention mental health services for children & young people; ↑ access and quality of mental health services for adults; ↑ early identification of health conditions in communities with the greatest health inequalities

Transformational priorities:
- **Moving more - Get Set Leeds**
- **Building prevention into everything we do**

People at the centre of their care

Goal: People feel that services work with them as an equal partner in their health and care, and see them as a whole person – this means their physical, emotional, and mental health are all considered in the context of their family and social connections

Building on continuous improvement: ↑ support people with long-term conditions in a way that works for them; ↑ chances to be active, socially connected and maximise time spent in a fulfilling home life; ↑ annual health check offer to help people stay well, particularly those with autism, learning disabilities or mental ill health; ↑ support people to die in their place of choice wherever possible

Transformational priorities:
- **Universal personalised care / strength and asset based person centred care**

Connected care closer to home

Goal: People interact with health, care and community services nearer to where they live. Underpinned by Local Care Partnerships. Health and care professionals in the hospital work in an integrated way with community services

Building on continuous improvement: ↑ access to support for children and families in community based child and family health and wellbeing hubs; ↑ mental health support in communities reducing mental health placement outside of Leeds; ↑ specialist support in communities for people with frailty; ↑ quality of medicines management; ↓ visits to the hospital where they could be provided elsewhere effectively especially outpatient appointments; ↑ access to quality information in reaching the right urgent care service; ↑ dedicated teams to support those living with learning disabilities / autism to live will in communities; ↑ urgent treatment centres; ↑ support to people with dementia to live independently

Transformational priorities:
- **Local Care Partnerships (LCPs)**

What will help us get there?

Working using **population outcomes** to focus services and activities on what matter most for people. Working as if we are one organisation and growing our own **workforce** from our diverse communities, supported by leading and innovative workforce education, training and technology. Making Leeds a centre for good growth becoming the place of choice in the UK to live, to study, for businesses to invest in, for people to come and work. Having the best connected city using **digital** technology to improve health and wellbeing in innovative ways. Using existing **estate** more effectively, ensuring that they are right for the job. Using our collective sound **financial** evaluation to get the best value for our 'Leeds £'.Through clear communications and engagement create a common language and voice.

How we know we are improving

- Increase the health and care contribution to the prevention of ill health
- Increase the number of people who live well in their own homes and communities
- Improve the mental health of people living in Leeds
- How does it feel for me? – listening to people's journey of care

RESULT: A healthy city with high quality services, where people who are the poorest improve their health the fastest

Better Care Fund 2019/20 Template

2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 0.1

Please Note:
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- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leeds
Completed by:	Lesley Newlove, Richard Huskins, John Crowther, Rob Good
E-mail:	lesley.newlove@nhs.net
Contact number:	0113 8432124
Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Rebecca Charlwood
Will the HWB sign-off the plan after the submission date?	No
If yes, please indicate the date when the HWB meeting is scheduled:	

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Rebecca	Charlwood	rebecca.charlwood@leeds.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Tim	Ryley	tim.ryley@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	N/A	N/A	N/A	N/A

	Local Authority Chief Executive		Tom	Riordan	tom.riordan@leeds.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Cath	Roff	cath.roff@leeds.gov.uk
	Better Care Fund Lead Official		Rob	Goodyear	rob.goodyear@nhs.net
	LA Section 151 Officer		Victoria	Bradshaw	victoria.bradshaw@leeds.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

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

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Strategic Narrative	No
5. Income	Yes
6. Expenditure	No
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover

^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	No

Sheet Complete	No

4. Strategic Narrative

^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	No
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	No

B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	No
C) System level alignment:	B44	No

Sheet Complete	No

5. Income

^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure

^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	No
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	No

7. HICM

^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes

Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics ^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements ^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes

PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Leeds

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£7,302,720	£7,302,720	£0
Minimum CCG Contribution	£55,238,834	£55,238,834	£0
iBCF	£27,399,640	£27,399,640	£0
Winter Pressures Grant	£3,310,729	£3,310,729	£0
Additional LA Contribution	£2,462,000	£2,462,000	£0
Additional CCG Contribution	£0	£0	£0
Total	£95,713,923	£95,713,923	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£15,697,310
Planned spend	£29,474,160

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£15,988,500	
Planned spend	£15,464,674	Planned spend is less than the minimum required spend

Scheme Types

Assistive Technologies and Equipment	£5,799,503
Care Act Implementation Related Duties	£0

Carers Services	£2,272,211
Community Based Schemes	£3,415,660
DFG Related Schemes	£7,302,720
Enablers for Integration	£1,659,842
HICM for Managing Transfer of Care	£2,866,104
Home Care or Domiciliary Care	£292,000
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£531,400
Intermediate Care Services	£14,371,790
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£2,141,204
Residential Placements	£469,529
Other	£54,591,960
Total	£95,713,923

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Mature
Chg 2	Systems to monitor patient flow	Mature
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Not yet established
Chg 6	Trusted assessors	Mature
Chg 7	Focus on choice	Mature
Chg 8	Enhancing health in care homes	Mature

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	564.4378042

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.85

[Planning Requirements >>]

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	No
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board:	Leeds

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

A) Person-centred outcomes
Your approach to integrating care around the person, this may include (but is not limited to):

- Prevention and self-care
- Promoting choice and independence

A proactive approach to prevention and reducing health inequalities
Our Health and Wellbeing vision is that 'Leeds will be a healthy and caring City for all ages where people who are the poorest improve their health the fastest'. 'We put people first. We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce. This is essential to our approach in addressing health inequalities in the City.
In order to address health inequalities, Leeds has identified the people in the City living in the 10% most deprived areas nationally as a priority for action.

There is a wealth of information about the differences in health experienced by this group of people, with some interesting points to note:
• 23% of people live in 'deprived Leeds', however,
• 26% of avoidable deaths, and
• 30% of preventable life years lost are for people living in these areas.

Particular outliers in terms of causes of avoidable death for people living in 'deprived Leeds' are infections, maternal infant and neurological. However, cancer, CVD and respiratory still account for the most deaths in these areas; since 2013 premature mortality from these conditions in these communities is increasing.

In addition to geographic inequalities, we also need to consider the challenges faced by marginalised and vulnerable groups of people as there is significant evidence that these have significantly worse health outcomes than the general population. These populations include the economically disadvantaged, children in poverty, families who experience in-work poverty, ethnic minority groups, the unemployed, low-income children, looked after children, older people, the homeless and those with long-term physical and mental health conditions, including people with learning disabilities and severe mental illness. These populations reside in all geographical areas, deprived and more affluent.
And whilst these two divisions (geographic and vulnerable groups) are useful to help to shape our

work, they are not exhaustive and we cannot ignore other groups / areas of the City given that the health outcomes in Leeds as a whole are often poorer than those of England.

In Leeds we will work to address health inequalities at three levels:
1. Wider Determinants: Actions to improve 'the causes of the causes' such as increasing access to good work, improving skills, access to employment, housing and the provision and quality of green space and other public spaces and Best Start initiatives.

We will take a partnership approach to ensure that we deliver a wider social impact, including on the employment of local people, air pollution and addressing the climate crisis, all of which disproportionately affect the poorest in society.
We will ensure that our estates planning and investment optimises the health effects of the built environment, and will always look for and take opportunities to co-ordinate resources with partners to maximise impact.

2. Prevention: Actions to reduce the causes, such as improving health behaviours - stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity form part of our 'Making every contact count' approach across the healthcare system.

• We will work in partnership to ensure preventive approaches are included in all care pathways, and to ensure that staff have access to prevention and wellbeing services.

• We will support investment in evidence based prevention services where we know this will improve health outcomes, and will focus this investment in the most deprived areas of the City and with marginalised and vulnerable groups.

3. Treatment: Actions to improve the provision of and access to healthcare and the types of interventions planned with a proactive personalised care approach through primary care management and integrated redesign of secondary care services, including outpatient services.
Access
We will ensure that services are delivered in ways which optimises access for people from disadvantaged groups. This included considering geography, transport, digital inclusion, language and culture. In order to understand this, we will continuously review access levels to services to ensure that current arrangements do not further disadvantage people experiencing the poorest health.

A Stronger Partnership with 3rd Sector
We will act to ensure that the strong, vibrant and diverse third sector of community and voluntary organisations continues to be at the heart of care and support services being provided in the City. This will include investment and support so that as well as being key providers of services, our third sector organisations are actively contributing to and informing the development of health and care services across the City and in local communities.

Reducing variation
We have developed robust processes to benchmark ourselves against our peers and reduce unwarranted variation. NHS Rightcare is invaluable in this task and we supplement this with local data. An example of an area where this is used routinely is in Long Term Conditions.
Leeds has a long history of developing personalised care and supportive self-management approaches. We have used the House of Care model to develop approaches that support people to manage their own health, for example reviewing and improving pulmonary rehab and diabetes education to ensure they are accessible to all, developing Breathe easy peer support, rolling out the

use of mycopd as a digital tool for self-management. We have also embedded collaborative care and support planning within the reviews for long term conditions across all 97 of our practices. Better Conversations is our universal approach to 'working with' people and the last year has seen over 900 people participate in the programme. Through our Personalised care Steering group we have moved forward on all 6 areas of the universal personalised care model. We are now developing a co-production group to steer this work locally.

The third sector has valuable expertise in this area and also the Leeds Social Prescribing model is ahead of the curve in terms of citywide provision and exemplary cross sector working which is enabling this third sector-led service to be fully embedded in terms of SystmOne and information sharing.

• Social Prescribing - the CCG has now commissioned a single City-wide social prescribing service model. 18 of our 19 PCNs have taken up the opportunity to fund an additional link worker and there is the opportunity if PCNs request for these link workers to be employed by the City-wide service. Our ambition is for there to be over 5,500 people supported each year through social prescribing in Leeds.

• Shared decision making (SDM) has already successfully been tested as an approach in Leeds within the MSK pathway, and we are now planning how this is rolled out to other specialities.

• Personalised care and support planning – Leeds has embedded collaborative care and support planning (CCSP) across all 97 practices as the method for long term conditions reviews. The total amount of CCSP Annual reviews performed in Leeds 85,859 between April 1 2018 and March 31 2019. From April 2019, the CCSP training will be incorporating the Better Conversations training. Our trajectory for 2019-20 is 107,337.

• Enabling Choice - A new contract schedule for personalised care has been included in all NHS contracts including details related to 'Choice'. LTHT will be working as a pilot site for the 'choice at 6 months' initiative, and already works closely with the CCG where appropriate clinical alternatives are available. All our local consultant led services are already published on E-Referral.

• Self-management – We are looking to further expand capacity in our main structured education programmes (Cardiac rehab, pulmonary rehabilitation) and to continue to consider innovative ways to deliver the key components of these services to support improved self management. Leeds has invested heavily in Diabetes structured education and continues to expand referrals into the National diabetes prevention programme (with an ambition of 10072 referrals for 2019) Leeds is supporting an infrastructure of peer support groups. Initially this has led to 7 breathe easy groups in the City, now a developing network and volunteer training. In addition we continue to roll out mycopd with up to 1,097 people using them in 2019. Work to make patient information available in a more consistent format and in easy to access locations is also a key aspiration in the coming 12 months.

• Patient Activation Measures (PAMs) usage has significantly increased this year with a total of 1060 initial PAMS and 58 repeat PAMs being administered totalling at 1118. To enable a growth in this number a PAMS implementation group has been formed to bring strategic leaders from implementing organisations together to steer the system towards implementing PAMs. Our trajectory for 2019-20 is 1156. These measures are now routinely built into a number of our pathways and new service procurements such as the newly procured Tier 3 weight management service.

• Personal Health Budgets (PHB) – Leeds has doubled our trajectory levels for the number of people being offered a PHB, including all people eligible for a personal wheelchair budget. PHBs are now being offered for people in receipt of section 117. Our ambition is to offer them to people requiring transportation for renal dialysis to enable them to choose transport options which best meet their needs.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):

- Joint commissioning arrangements
- Alignment with primary care services (including PCNs (Primary Care Networks))
- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

Integrated Commissioning, PCNs and the Voluntary Sector
We have an Integrated Commissioning Framework that is based on the principle that the health and care system across Leeds works collaboratively to enhance and further develop integrated health and care services, and where it makes sense to do so, to put in place integrated commissioning arrangements as the means by which those services are developed.

The Integrated Commissioning for Better Outcomes toolkit has been used to evaluate the progress in Leeds on our integrated commissioning arrangements. This provides an outline of the strengths well as identifying areas where further development is required.

Our objectives
Our commissioning decisions are based on the following objectives:
• Develop Population Health Management (PHM) as the means to identify and deliver population-based outcomes
• Support a strengths-based approach
• Invest in evidence-based prevention and early intervention services
• Invest in services which help reduce health inequalities
• Promote person-centred, personalised care, enabling choice and control, including through Personal Health Budgets (PHBs)
• Ensure services are co-produced
• Help develop a sustainable health and care market including the Third Sector
• Support the Left Shift by increasing the capability of communities and community provision

One key commissioning objectives is to further develop community based services which help people, whatever their age or their health and care needs, to remain living independently in their own homes and which reduce avoidable hospital admissions.

To help deliver on this objective, through the application of PHM, priority will be given to developing integrated commissioning arrangements in the following:
• Older people's residential and nursing care homes
• Dementia services
• Intermediate care and reablement services
• Home care
• Mental Health services
• Learning Disability, Autism and Dual Diagnosis Services
• Children and Families Services and Transitions
• Support to informal/unpaid Carers. There are also more than 74,000 people in Leeds who give their time as a carer, upon which we rely so heavily and without whom our city would be a worse place to be.
• Supporting a diverse and thriving Third Sector provider market. Our Third Sector is a source of genuine pride in the city, with an enormous range of organisations embedded and working within communities to make a real difference.

Our progress to date
We have developed and continue to refine a number of joint strategies which inform key strategic commissioning decisions and service developments. These include:
• Carers strategy
• Dementia strategy
• Autism strategy
• 'Being Me', the Learning Disability strategy
• An all-age Mental Health strategy

Through our integrated commissioning arrangements we have been developing:
• Supported Living services for adults with learning disabilities and delivery of the Transforming Care Programme
• Reablement and rehabilitation services including Community Care Beds
• Equipment and telecare services
• Integrated carers' support services

We have pooled elements of our funding through the BCF and iBCF to develop a range of services which:
• Support people to maintain their health and wellbeing at home, including preventing avoidable hospital admissions
• Ensure care and support is provided when people require care in an acute hospital setting
• Ensure support is provided to people to help them to return to their own home following a period of ill health

Next steps
We will consider opportunities for extending further and optimising the BCF as a means of pooling funding where it may help to deliver cost efficiencies and to result in improved outcomes for people. This includes consideration of our collective investment in our Third Sector with the aim of maximising opportunities to enhance or further develop a comprehensive range of preventative services at neighbourhood level.

We will consider the best ways in which we can increase the use of PHBs to support personalised care and to enable people to exercise choice and control over their health and care services.

As we develop our PHM approach we will review the use of the BCF/iBCF to ensure our pooled resources are being utilised to the maximum effect and are being targeted appropriately at reducing health inequalities and at the expansion of preventative and early intervention services to help achieve the Left Shift.

Local Care Partnerships (LCPs)
These form the basis of locally integrated health, wellbeing and care, rooted in communities, using 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. They bring together the full range of a community's assets to design and deliver integrated care that best meets the needs of the local population.

LCPs are community driven and put people and partnerships at the centre of how care models are designed, delivered and evaluated. Each will have strong leadership teams in place that are inclusive and representative of the statutory, voluntary and independent sectors. There is a strong interdependency between LCPs and our PHM approach, which is being implemented at a LCP level and will inform the way in which they operate.

C) System level alignment, for example this may include (but is not limited to):

- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans
- A brief description of joint governance arrangements for the BCF plan

Leeds has an ambition to be the Best City in the UK by 2030 which includes being the best city for Health and Wellbeing. To this end Leeds developed a Health and Wellbeing Strategy for 2016-2021 which is being delivered largely through the Leeds Health and Care Plan (known as the Leeds Plan.)

The Leeds Plan is our local plan but we are also part of the West Yorkshire & Harrogate Integrated Care System which has strengthened joint working arrangements between all organisations involved.

The governance surrounding Leeds' approach to integrated commissioning ensures the BCF Plan underpins the aims and ambitions of both the WY&H ICS and the Leeds Plan and aligns with their objectives.

The Leeds Health and Wellbeing Board is the approval board for BCF and discharges its function through the Integrated Commissioning Executive (ICE) which also acts as the BCF Partnership Board. In previous years, a BCF Delivery Group was the operational group that provided advice and support to the BCF Partnership Board undertaking the detailed work involved in monitoring the operational delivery of the schemes and outcomes delivered by the BCF. A key role of the BCF Delivery Group was also to oversee the development and implementation of processes and procedures to support the management, delivery and monitoring of the BCF.

In 2018, it was agreed to merge the BCF Delivery Group and the Leeds Plan Delivery Group (LPDG) as both groups reported into ICE and some members sat on both groups. Membership of this revised LPDG includes appropriate representation from the original BCF Delivery Group ensuring robust governance and consistency continues. Membership of this group also includes colleagues from across the health and care system including representatives from the voluntary sector.

For iBCF schemes, commissioning decisions are incorporated within the plan, and remain the responsibility of ICE; the execution of those decisions is undertaken by the revised LPDG. All iBCF schemes are aligned to relevant programme boards to oversee monitoring and reporting and ensure that they are contributing to the overall delivery of the aims of the Leeds Health and Wellbeing Strategy and Leeds Plan.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Leeds

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leeds	£7,302,720
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£7,302,720**

iBCF Contribution	Contribution
Leeds	£27,399,640
Total iBCF Contribution	**£27,399,640**

Winter Pressures Grant	Contribution

Leeds	£3,310,729
Total Winter Pressures Grant Contribution	**£3,310,729**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Leeds	£2,462,000	Represents Leeds City Council's contribution to the Leeds Equipment Service
Total Additional Local Authority Contribution	**£2,462,000**	

CCG Minimum Contribution	Contribution
NHS Leeds CCG	£55,238,834
Total Minimum CCG Contribution	**£55,238,834**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£55,238,834**	

	2019/20
Total BCF Pooled Budget	**£95,713,923**

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

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Leeds

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£7,302,720	£7,302,720	£0
Minimum CCG Contribution	£55,238,834	£55,238,834	£0
iBCF	£27,399,640	£27,399,640	£0
Winter Pressures Grant	£3,310,729	£3,310,729	£0
Additional LA Contribution	£2,462,000	£2,462,000	£0
Additional CCG Contribution	£0	£0	£0
Total	£95,713,923	£95,713,923	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend	
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£15,697,310	£29,474,160	£0	
Adult Social Care services spend from the minimum CCG allocations	£15,988,500	£15,464,674	£523,826	Planned spend is less than the minimum required spend

Link to Scheme Type description

						Planned Outputs		Metric Impact				Expenditure							
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
3	SkILs Reablement Service	To increase system flow of patients by placing Case Officers in LTHT and having dedicated Social Work Assistants to support timely exits from reablement where an ongoing service is required.	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	Medium	Medium	High	Social Care		LA			Local Authority	iBCF	£270,812	Existing
7	Supporting Wellbeing and Independence for Frailty (SWIFt)	The aim of this service is to work with older people who are living with frailty, socially isolated and with complex issues to improve their quality of life and support them to live independently by: • Helping them to identify ways to build self-confidence and resilience • Providing practical support to help them achieve their aspirations • Ensuring they are accessing the support services they require	Community Based Schemes					Medium	Not applicable	Medium	Not applicable	Social Care		LA			Local Authority	iBCF	£120,000	Existing
8	Customer Access		Enablers for Integration	Shared records and Interoperability				Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£42,792	Existing
12	Asset Based Community Development (ABCD)		Community Based Schemes					Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£258,000	Existing
13	Dementia: Information & Skills (online information and training)		Community Based Schemes					Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£155,000	Existing
14	Falls Prevention		Community Based Schemes					High	Not applicable	Medium	Not applicable	Community Health		CCG			NHS Community Provider	iBCF	£130,000	Existing
15	Time for Carers		Carers Services	Respite Services				Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£75,000	Existing
17	Working Carers		Carers Services	Carer Advice and Support				Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£25,000	Existing
21	Prevent Malnutrition Programme	To fund a programme of work known as the 'Leeds Malnutrition Prevention Programme' that will include:- a) a series of malnutrition campaigns b) the dissemination of resources c) the increased effectiveness and capacity of the older people nutrition training (Improving Nutritional Care & Nutritional Champions) across the health and social care workforce and allied health professionals d) the reintroduction of the 2012 'Winter Pressure Project' which included a single point of contact for health and social care professionals who identified an older person to be at risk of malnutrition.	Community Based Schemes					Medium	Not applicable	Medium	Not applicable	Social Care		LA			Local Authority	iBCF	£12,750	Existing
22	Better Conversations	To train health and care staff to have 'better conversations' with the citizens of Leeds and move the conversation to a 'working with' approach.	Community Based Schemes					Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£608,000	Existing
23	Alcohol and drug social care provision	To fund front line drug and alcohol services for residential rehabilitation, Turning Lives Around (formerly Leeds Housing Concern) and spot purchase in order to meet the needs of patients requiring specialist drug and alcohol services.	Residential Placements	Supported Living		Placements	39.0	High	Medium	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£469,529	Existing
25	Peer Support Networks	To develop a sustainable network of peer support groups across Leeds for people living with Long-term conditions	Community Based Schemes					Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£70,000	Existing
26	Lunch Clubs	To continue to fund the Lunch Club small grants scheme for 2018/19 targeted at older people, with the aim of decreasing their social isolation; increase their opportunity to access a nutritional meal and decrease their need for care and support.	Community Based Schemes					Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£166,500	Existing

28	The Conservation Volunteers (TCV Hollybush) Green Gym	To fund Green Gyms where participants are guided in practical activities such as gardening and grounds maintenance. TCV will run four weekly sessions spread across Leeds and two health walks groups. There will also be an extensive programme of outreach and pop up sessions to recruit from the target populations.	Community Based Schemes					Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£175,630	Existing
30	Neighbourhood Networks	Neighbourhood Network schemes are community based, locally led organisations that enable older people to live independently and proactively participate within their own communities by providing services that reduce social isolation, deliver a range of health and wellbeing activities, provide opportunities for volunteering, act as a 'gateway' to advice/information and other services resulting in a better quality of life for individuals.	Community Based Schemes					high	Low	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£564,000	Existing
31	Leeds Community Equipment Service	To increase the funding for the Leeds Community Equipment Service	Assistive Technologies and Equipment	Community Based Equipment				Not applicable	Medium	Not applicable	Medium	Social Care		LA			Local Authority	iBCF	£350,000	Existing
34	Ideas That Change Lives (ITCL) Investment Fund	To 'top up' the current ITCL investment fund as it is currently oversubscribed. The additional funding will be particularly focused on encouraging the development of social enterprises in more deprived communities and the business support that works alongside the fund will also be refocused to support this.	Community Based Schemes					Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£25,000	Existing
35	A&H - Change Capacity	To create a call off provision dealing with short term back-office provision - particularly linked to strengths based social care and maintaining a stable care market	Other		The purpose of this scheme is to refine processes and ensure that care packages, provider payments and invoices are dealt with promptly			Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£100,000	Existing
37	Assisted Living Leeds Volunteer Drivers	To create volunteer driver posts at Assisted Living Leeds to collect small items of equipment, that do not require any technical ability to disassemble or remove, such as Zimmer frames, commodes, pick up sticks cushions etc.	Assistive Technologies and Equipment	Community Based Equipment				Not applicable	Not applicable	Not applicable	Low	Social Care		LA			Local Authority	iBCF	£32,000	Existing
44	Positive Behaviour Service	This bid is for a Positive Behaviour Service which will work intensively with young people with behaviours that challenge and learning disabilities at risk of needing external residential placements, reducing the need for residential placements or emergency hospital treatment and admissions in childhood and adult life.	Community Based Schemes					Medium	Not applicable	Low	Not applicable	Social Care		LA			Local Authority	iBCF	£199,204	Existing
49	YAS Practitioners Scheme	To fund two Emergency Care Practitioners to be based at the Urgent Treatment Centres who will provide both navigation services and support to minor illness and minor injuries through clinic sessions. To also fund 1 part-time ECP supervisor.	Integrated Care Planning and Navigation	Care Coordination				Medium	Not applicable	Not applicable	Not applicable	Acute		CCG			NHS Acute Provider	iBCF	£181,400	Existing
50	Frailty Assessment Unit	To fund a multi-agency frailty service initially in St James' to support a strength based approach to the management of frail people presenting or conveyed to the emergency department and promote the ethos of Home First.	Integrated Care Planning and Navigation	Care Coordination				High	Medium	Medium	Low	Acute		CCG			NHS Acute Provider	iBCF	£350,000	Existing
52	Hospital to Home	To fund the Leeds Integrated Discharge Service – a multi-disciplinary team to ensure that where possible admissions into hospital are avoided from A&E and the assessment area. In addition the team works across a number of medical wards to support timely discharge of adult medical patients who have presented to the hospital.	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	Medium	Medium	Low	Community Health		CCG			Charity / Voluntary Sector	iBCF	£105,000	Existing
54	Staffing Resilience	Contingency funding for 3 agency Social Workers to cover any exceptional surges in LTHT and out of Leeds inpatient facilities during the winter period	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	Medium	Low	Low	Social Care		LA			Local Authority	iBCF	£109,437	Existing
55	Business Support for Discharge Process	To fund additional Business Support in HSW to accommodate the centralisation of all hospital discharges within the HSW service. This additional Business Support will enable Social Workers to smoothly discharge Leeds residents from hospital settings. Business Support provides essential capacity to the Social Work role, and also undertakes quality checks on resource allocation requests	HICM for Managing Transfer of Care	Chg 2. Systems to Monitor Patient Flow				Not applicable	Medium	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£54,171	Existing
61	Falls Pathway Enhancement	The Falls scheme is predominantly focussed on older people living with frailty people, particularly those with multiple long-term conditions living in their own homes or in care homes. However the increase in diabetes is also having an impact on the risk of falls in younger adults. This work will predominantly affect the citywide Falls pathway, with links to long-term conditions and frailty pathways.	Community Based Schemes					High	Not applicable	Medium	Medium	Community Health		CCG			NHS Community Provider	iBCF	£159,243	Existing
64	Trusted Assessor (LGI)	The bid for Trusted assessors is to increase the capacity of the LIDS service to enable cover to be extended to wards on the LGI site.	HICM for Managing Transfer of Care	Chg 6. Trusted Assessors				Not applicable	High	Low	Low	Acute		CCG			NHS Acute Provider	iBCF	£200,000	Existing
65	Trusted Assessor (SJH)	The bid for Trusted assessors is to increase the capacity of the LIDS service to enable cover to be extended to all wards on the St James site.	HICM for Managing Transfer of Care	Chg 6. Trusted Assessors				Not applicable	High	Low	Low	Acute		CCG			NHS Acute Provider	iBCF	£200,000	Existing
71	Burmantofts Health Centre Redevelopment	To redevelop the Burmantofts Health Centre	Community Based Schemes					Not applicable	Not applicable	Not applicable	Not applicable	Community Health		CCG			NHS Community Provider	iBCF	£100,000	Existing
73	Physical Activity - Social Movement	To create a social movement to get more people, more physically active, more often. The proposal has two distinct components; 1. To promote a 'physical activity' conversation across the city 2. To co-produce an ambition and action plan for physical activity in Leeds.	Community Based Schemes					Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£101,455	Existing
75	Health Digital Inclusion	To develop a sustainable offer to tackle digital inclusion across Leeds for people living with long-term conditions.	Assistive Technologies and Equipment	Community Based Equipment				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£76,000	Existing
76	Therapy Supported Discharge (Home First)	To scale up the existing Home First approach so it can be further tested and embedded over an 18 month period.	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Not applicable	High	Medium	Medium	Community Health		CCG			NHS Community Provider	iBCF	£160,301	Existing
81	Hospital to Home - Community Extension	To develop additional H2H capacity to strengthen short-term follow up (7 days) in the community after discharge from hospital in order to increase independence for older people leaving hospital.	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Not applicable	Not applicable	Medium	Low	Community Health		CCG			Charity / Voluntary Sector	iBCF	£48,654	Existing
82	Extend Independence at Home Service to 7 days	To extend the Independence at Home Service/SWIFt to 7 days per week	Community Based Schemes					Not applicable	Not applicable	Medium	Low	Community Health		LA			Local Authority	iBCF	£115,878	Existing
85	SWIFt Expansion	To secure further funding to progress with the re-procurement of a future model for the Supporting Wellbeing and Independence for Frailty (SWIFt) service.	Community Based Schemes					Medium	Not applicable	Low	Not applicable	Social Care		LA			Local Authority	iBCF	£300,000	Existing
95	Leeds Oak Alliance: LTHT Third Sector Hub	To pilot a Third Sector Hub in LTHT provided by the Leeds Oak Alliance.	Enablers for Integration	Integrated workforce				Not applicable	Medium	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	iBCF	£150,000	Existing
100	Digital Access for PH Wider Workforce	To enhance our current digital offer within the Public Health Resource Centre (PHRC) to enable the Leeds health and care workforce to access evidence based information.	Assistive Technologies and Equipment	Digital Participation Services				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£49,503	Existing

								<Please Select>	<Please Select>	<Please Select>	<Please Select>	<Please Select>		<Please Select>			<Please Select>	<Please Select>		
301	Increase in Budgeted and Actual Home Care Expenditure - 2019/20	Additional provision made in 2019/20 to cover increased demand for Homecare	Enablers for Integration	Market development (inc Vol sector)				Not applicable	Low	Not applicable	Not applicable	Social Care		LA			Local Authority	Winter Pressures Grant	£900,000	Existing
302	Development of Bridging Service from within Reablement Service	Rapid Pick up within 24 hours from hospital of MFD patients	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	High	Low	Not applicable	Social Care		LA			Local Authority	Winter Pressures Grant	£560,000	Existing
303	Development of Independent Sector Rapid Pick up service	Rapid Pick up within 24 hrs from hospital, community beds, reablement	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Not applicable	High	Low	Medium	Social Care		LA			Local Authority	Winter Pressures Grant	£435,729	Existing
304	Pay Home Care Providers for up to 14 days whilst SU in hospital	Ensures availability and continuity of care to facilitate Discharge	Home Care or Domiciliary Care	<Please Select>				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Winter Pressures Grant	£222,000	Existing
305	Accelerate and extend 1-2-1 support for complex needs nursing care	Facilitate complex needs cases to stabalise in Nursing Care	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	Medium	Low	Low	Social Care		LA			Local Authority	Winter Pressures Grant	£200,000	Existing
								<Please Select>	<Please Select>	<Please Select>	<Please Select>	<Please Select>		<Please Select>			<Please Select>	<Please Select>		
307	Trusted Assessors for Discharge to Residential Care x2	Facilitate suitable residential placements to facilitate discharge into residential care	HICM for Managing Transfer of Care	Chg 6. Trusted Assessors				Not applicable	Medium	Medium	Low	Community Health		LA			Local Authority	Winter Pressures Grant	£120,000	Existing
308	Additional Social Work Capacity to support Community Beds x6	Improve and Maintain outflow from Community Care Beds	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	6.0	Not applicable	High	Low	Low	Community Health		LA			Local Authority	Winter Pressures Grant	£251,000	Existing
309	Wellbeing Workers x3	One x C1 workers per each area of the city to support rapid response/CCB's	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	Medium	Low	Low	Community Health		LA			Local Authority	Winter Pressures Grant	£81,000	Existing
310	Business Support & Infrastructure Costs to support above	3 x B1 workers plus IT/phones to support 12 staff in discharge facilitation	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	High	Not applicable	Not applicable	Acute		LA			Local Authority	Winter Pressures Grant	£66,000	Existing
311	Trial Weekend working - management cover in LTHT	Support weekend discharge - formerly proposed to be WYAZ funded	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	High	Low	Low	Acute		LA			Local Authority	Winter Pressures Grant	£30,000	Existing
312	Support the Development of Community Catalysts	Development of boutique home care provision in difficult to recruit areas of the city	Home Care or Domiciliary Care			Packages		Not applicable	Medium	Low	Low	Social Care		LA			Local Authority	Winter Pressures Grant	£70,000	Existing
313	Winter Grants/Ideas that Change Lives	Grants for older people/social enterprise start up - admission avoidance	Community Based Schemes					Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	Winter Pressures Grant	£40,000	Existing
314	Home Plus Service	Warmth & Falls Initiatives to cover 100 households	Community Based Schemes					Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Winter Pressures Grant	£20,000	Existing
315	Neighbourhood Networks	£40k Grants for Winter Wellbeing initiatives & £50k for Infection Prevention Initiatives	Community Based Schemes					Medium	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Winter Pressures Grant	£90,000	Existing
316	Infection Prevention & Control	Training and Prevention Advice to all providers	Other		The purpose is to provide training and prevention advice to providers			Medium	Not applicable	Low	Low	Social Care		LA			Local Authority	Winter Pressures Grant	£50,000	Existing
317	Long Term Conditions/Peer Support Groups	Pulmonary Rehab/Breathe Easy Groups & peer support for LTC	Community Based Schemes					Medium	Not applicable	Not applicable	Not applicable	Social Care		CCG			NHS Community Provider	Winter Pressures Grant	£5,000	Existing
318	Carers Leeds - Winter Allocation	Additional grants for carers - winter breaks/services via Carers Leeds	Carers Services	Respite Services				Medium	Low	Not applicable	Not applicable	Social Care		LA			Charity / Voluntary Sector	Winter Pressures Grant	£40,000	Existing
319	Business Analysts - ongoing Newton Europe system analysis	Ongoing information refresh of Newton Europe analysis - monitor impact	HICM for Managing Transfer of Care	Chg 2. Systems to Monitor Patient Flow				Not applicable	High	Medium	Medium	Acute		CCG			CCG	Winter Pressures Grant	£30,000	Existing
								<Please Select>	<Please Select>	<Please Select>	<Please Select>	<Please Select>		<Please Select>			<Please Select>	<Please Select>		
321	BI/Finance and Performance Support to administer monitor impact	BI/Finance and Performance Support to monitor impact	Enablers for Integration	Implementation & Change Mgt capacity				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Winter Pressures Grant	£100,000	Existing
421	Contribution to social care demand pressures	Contribution to social care demand pressures	Other		This is a contribution to social care demand pressures			Medium	Medium	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£21,089,381	Existing
400	Reablement Services	Reablement services	Intermediate Care Services	Reablement/Rehabilitation Services		Packages		Not applicable	High	Low	High	Community Health		CCG			Local Authority	Minimum CCG Contribution	£2,807,000	Existing
401	Community beds	The community beds service provides intermediate care in the community	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	219.0	Not applicable	High	High	Medium	Community Health		CCG			Private Sector	Minimum CCG Contribution	£9,921,630	Existing
402	Community beds	The Green	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	30.0	Not applicable	High	High	Medium	Community Health		CCG			Local Authority	Minimum CCG Contribution	£1,392,160	Existing
418	Supporting carers	A range of services to support carers	Carers Services	Carer Advice and Support				Medium	Medium	Not applicable	Not applicable	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,500,475	Existing
403	Supporting carers	A range of services to support carers	Carers Services	Respite Services				Medium	Medium	Not applicable	Not applicable	Continuing Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£278,126	Existing
404	Supporting carers	A range of services to support carers	Carers Services	Respite Services				Medium	Medium	Not applicable	Not applicable	Community Health		CCG			Local Authority	Minimum CCG Contribution	£353,610	Existing
405	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community Based Equipment				Not applicable	Medium	Not applicable	Medium	Community Health		CCG			Local Authority	Minimum CCG Contribution	£2,830,000	Existing
406	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community Based Equipment				Not applicable	Medium	Not applicable	Medium	Community Health		LA			Local Authority	Additional LA Contribution	£2,462,000	Existing

419	3rd Sector prevention	Mental Health Prevention Services	Other		These are various mental health prevention services provided by the 3rd sector			Medium	Not applicable	Not applicable	Not applicable	Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£4,245,589	Existing
420	3rd Sector prevention	Community Health Prevention Services	Other		These are various communuty support services provided by the 3rd sector			Medium	Not applicable	Not applicable	Not applicable	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£502,316	Existing
407	Admission avoidance	Crisis support/diversion from hospital	Other		Service to ensure people who are admitted to hospital are managed appropriately on discharge to support them to live at home and avoid re-admission			High	Not applicable	Not applicable	Not applicable	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£2,800,000	Existing
408	Community Matrons	Health Care in the community	Other		Provision of community matrons in all community settings to support case management of patients where required			Medium	Medium	Not applicable	Not applicable	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,600,000	Existing
409	Homeless Accommodation Leeds Pathway (HALP)	To provide transitional accommodation for homeless patients after a stay in hospital	Other		To provide dedicated beds at St George's Crypt to provide transitional accommodation for homeless patients to facilitate timely discharge after a stay in hospital			Not applicable	Medium	Not applicable	Not applicable	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£240,000	Existing
410	Interface Geriatricians	Community Geriatrician service to deliver a consultant led; community facing service for frail elderly patients providing direct patient care to patients and, direct clinical advice and support to the Neighbourhood Teams, and Primary Care.	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Not applicable	High	Not applicable	Not applicable	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£195,000	Existing
411	Disabled Facilities Grant	Means-tested grant to cover the cost of housing adaptations that help disabled people to live independently in their own homes	DFG Related Schemes	Adaptations				Not applicable	High	Not applicable	Low	Social Care		LA			Local Authority	DFG	£7,302,720	Existing
412	Social Care to Health Benefit	Social care to health benefit	Other		Funding for social care to benefit health services			Medium	Low	Low	Low	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£13,414,674	Existing
413	Contingency	Contingency fund	Other		Contingency set aside for any NEA shortfall			Medium	Medium	Medium	Medium	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£7,500,000	Existing
414	Care Bill	To cover the financial costs associated with the Care Act	Other		To cover the financial costs associated with the Care Act			Medium	Low	Low	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,900,000	Existing
415	Enhancing Primary care	Primary care developments with the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding is used to enhance services to support the management of this patient cohort.	Prevention / Early Intervention	Risk Stratification				Medium	Not applicable	Low	Low	Primary Care		CCG			CCG	Minimum CCG Contribution	£2,141,204	Existing
416	Information Technology	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.	Enablers for Integration	Shared records and Interoperability				Low	Not applicable	Low	Low	Other	IT	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£467,050	Existing
417	Former local reform and Community voices grant	Former local reform and community voices grant	Other		A former social care grant transferred into the BCF			Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£150,000	Existing

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board:	Leeds

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:

- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

Leeds has embraced the work undertaken by Newton Europe to look at flow across the system. The outcomes of this work is best summarised in the system outcomes delivered in three sections below:-

1. Creating the right foundations
• Financial and operational opportunity validated including viability
• Readiness for change understood
• Historic risks understood
• System ownership and SRO agreed
• Implementation areas and owners agreed, including realistic targets

2. Winter 18/19
• Implementation activities completed
• Operational and behavioural changes sustained over winter
• A&E performance improved each month between 2-18%
• Maintaining a zero tolerance to caring for patients in non-designated areas - zero patients since May 2018
• Reducing the average number of outliers per day from 90 to 58
• Maintaining the standard of having no 12 hour trolley waits
• On average 58 fewer beds are occupied by super-stranded patients
• DTOC- reduced the average from 80 to 39 in 2018/19
• Reduced length stay on stroke wards from 34 to 18.5 days (national 20 days)
• Excellent flow through community beds

3. Winter 19/20
• A fundamental change in "how we do winter" in Leeds – activities agreed

Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?

Chg 1	**Early discharge planning**	Mature	Mature	
Chg 2	**Systems to monitor patient flow**	Mature	Mature	
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Mature	Mature	
Chg 4	**Home first / discharge to assess**	Established	Mature	
Chg 5	**Seven-day service**	Not yet established	Not yet established	Increasingly more services in Leeds are available over seven days and Leeds is continuing to develop this approach where it's demonstrable it adds value.
Chg 6	**Trusted assessors**	Mature	Mature	
Chg 7	**Focus on choice**	Mature	Mature	
Chg 8	**Enhancing health in care homes**	Established	Mature	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Leeds

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative	
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	The Leeds system invited Newton Europe back for a second time to look at admission avoidance. Their recommendations have been fed back and include community IV antibiotic pathway; working with YAS; access to the "front door" of the hospital around one day length of stay; working with the third sector such as Hospital to Home and PCNs around their roles.	**Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

Plans are yet to be finalised and signed-off so are subject to change;**for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative

Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	77.2	Acute Following initial work with Newton Europe, a system resilience plan is part of the delivery plan for both the SRAB and the A&E delivery board. These delivery plans also reflect feedback from CQC System Review, surge events and learnings from previous winters. The plan has been shared with the Leeds Plan Delivery Group to ensure the whole system is aware and has the opportunity to feed back. Mental Health DTOC remains a challenge with the city's mental health acute provider - particularly around those patients with challenging dementia who remain in inpatient beds in the trust's bed base. There is a recognised issue around capacity for those patients with challenging behaviour. Nursing home provision is a challenge within Leeds and recognising this, the system is working to manage and develop the market to help address this. A dementia steering group has been organised to oversee this work, and the CCG has provided additional funding to work with care homes and providers directly. Winter monies Existing and newly planned initiatives and pressures of over £9m have been identified relating to Winter Pressures over the 16 month period November 2018 to March 2020 and these have been shared and approved by SRAB. This compares to the available funding from the Winter Pressures money of £6.6m over the same period. This position has been enabled largely by using the 2018/19 allocation to fund the increased pressure on the LA Home Care Budget, therefore allowing the carry forward of savings made in year to cover this pressure prior to notification of the additional grant. This has allowed all of the priorities identified for 2019/20 to be funded up until 31st March 2020.	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	623	564	Leeds has in place a range of short term and long term services to support people in their own homes. This year an increase in community short term beds provision and reablement support coupled with a strength based approach has led to a reduction in permanent admissions especially from hospital.
	Numerator	763	700	
	Denominator	122,414	124,017	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%	85.0%	Leeds provides a wide range of support to people leaving hospital, including, streamlined processes to enable earlier and easier access to reablement services. These are now operating and numbers accessing the service have increased. A supported discharge service in the voluntary sector provides essential support in the first days of leaving hospital ensuring people have what they need including access to other services. An increased community beds service is now fully operating and providing more capacity for people who need to recuperate before returning home. Recent trends have shown a decrease in the percentage who are still at home 90 days afte discharge, there is a need to ensure that all people with capacity who wish to return home are provided with the opportunity, however, inevitably some will return to hospital, die or require a care home places. Therefore this year we are reducing the target to 85% to reflect an approach which is not too risk adverse.
	Numerator	994	425	
	Denominator	1,104	500	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Leeds

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	No		This is being dealt with through the Leeds System Resilience Assurance Board - part of this in response to Newton Europe	This will be delivered before 2020/21
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes			
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes			
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes			