Community Committee

Leeds CITY COUNCIL

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

**Report to:** Outer West Community Committee

**Report author:** Paul Bollom (Head of the Leeds Health and Care Plan, Health Partnerships)

**Date:** 22 November 2017 **To note**

# Leeds Health and Care Plan: Inspiring Change through Better Conversations with Citizens

## 1. Purpose of report

1.1 The purpose of this paper is to provide the Outer West Community Committee with an overview of the progress made in shaping the Leeds Health and Care Plan following the previous conversation at each Committee in Spring 2017. It is fundamental to the Plan's approach that it continues to be developed through working 'with' citizens employing better conversations throughout to inspire change. The conversation will ensure open and transparent debate and challenge on the future of health and care, and is based around the content of the updated plan and accompanying narrative. The aim is to consider the proposals made to date and support a shift towards better prevention and a more social model of health.

1.2 The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).

1.3 The Leeds Plan envisages a significant move towards a more community focused approach which understands that good health is a function of wider factors such as housing, employment, environment, family and community and is integral to good economic growth. There are significant implications for health and care services in communities and how they would change to adopt this way of working. The paper provides further information on these

1.4 For the changes to be effective it is proposed there are significant new responsibilities for communities in how they may adopt a more integrated approach to health and care and work with each other through informal and formal approaches to maximise health outcomes for citizens. This includes how community and local service leaders (including elected members) may support, steer and challenge this approach.

## 2. Main issues

2.1 The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).

2.2 The Leeds Health and Care Plan is the city's approach to closing the three gaps that have been nationally identified by health, care and civic leaders. These are gaps in health inequalities, quality of services and financial sustainability. It provides an opportunity for the city to shape the future direction of health and to transition towards a community-focused approach, which understands that good health is a function of wider factors such as housing, employment, environment, family and community.

2.3 Perhaps most importantly, the Leeds Health and Care Plan provides the content for a conversation with citizens to help develop a person-centred approach to delivering the desired health improvements for Leeds to be the Best City in the UK by 2030. It is firmly rooted in the 'strong economy, compassionate city' approach outlined in the Best Council Plan 2017-18.

2.4 The Leeds Health and Care Plan narrative sets out ideas about how we will improve health outcomes, care quality and financial sustainability of the health and care system in the city. The plan recognises the Leeds Health and Wellbeing Strategy 2016-2021, its vision and its outcomes, and begins to set out a plan to achieve its aims.

2.5 The Leeds Health and Wellbeing Board has a strong role as owner and critical friend of the Leeds plan championing an approach of 'working with' citizens throughout. The steer to the shaping of the Leeds Health and Care Plan has been through formal board meetings on 12th January and 21st April 2016 and two workshops held on 21st June and 28th July 2016. The Board has held a further workshop on 20th April 2017 where the previous Community Committee meeting feedback was given and more recently at a formal board meeting on 20th June 2017. The board has further reviewed progress on the 28th of September of the plan in the context of both short-term challenges for winter and wider transformation of primary care health and care services. Further comment on the draft plan and supporting narrative has been incorporated.

2.6 The plan recognises and references the collaborative work done by partners across the region to develop the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP – previously the STP), but is primarily a Leeds based approach to transformation, building on the existing strategies that promote health and inclusive growth in the city. Whilst the financial challenge is a genuine one, the Leeds approach remains one based on long term planning including demand management, behaviour change and transition from acute-based services towards community based approaches that are both popular with residents and financially sustainable.

2.7 A transition towards a community-focused model of health is outlined in the plan. This is the major change locally and will touch the lives of all people in Leeds. This 'new model of care' will bring services together in the community. GP practices, social care, Third Sector and public health services will be informally integrated in a 'Local Care Partnership'. Our hospitals will work closely with this model and care will be provided

closer to home where possible, and as early as possible. New mechanisms, known as 'Population Health Management' will be used to ensure the right people get the right services and that these are offered in a timely fashion. This is designed to prevent illness where possible and manage it in the community.

2.8 The Leeds Health and Care Plan narrative presents information for a public and wider staff audience about the plan in a way that that citizens and staff can relate to and which is accessible and understandable.

2.9 The Leeds Health and Care Plan narrative (when published) will be designed so that the visual style and branding is consistent with that of the Leeds Health and Wellbeing Strategy 2016-2021 and will be part of a suite of material used to engage citizens and staff with.

The narrative contains information about:

- The strengths of our city, including health and care
- The reasons we must change
- How the health and care system in Leeds works now
- How we are working with partners across West Yorkshire
- The role of citizens in Leeds
- What changes we are likely to see
- Next steps and how you can stay informed and involved

2.10 The final version will contain case studies which will be co-produced with citizen and staff groups that will describe their experience now and how this should look in the future.

2.11 It will enable us to engage people in a way that will encourage them to think more holistically about themselves, others and places rather than thinking about NHS or Leeds City Council services. Citizen and stakeholder engagement on the Leeds Health and Care Plan has already begun in the form of discussions with all 10 Community Committees across Leeds in February and March 2017.

2.12 The approach taken in developing the Leeds Plan has embodied the approach of 'working with' people and of using 'better conversations' to develop shared understanding of the outcomes sought from the plan and the role of citizens and services in achieving these.

## 3. Influence of Community Committees and Voice of Citizens

3.1 The Leeds Health and Care Plan has been substantially developed subsequent to the previous conversation in Community Committees in Spring 2017. The previous discussion outlined the key areas of challenge for health and care services both at a city level and within each locality. For this meeting of the Outer West Community Committee, please find attached the corresponding profiles for Integrated Neighbourhood Teams (INTs) to inform discussions (Appendix 1).

3.2 The four suggested areas for action in the Plan remain as: better prevention, better self-management and proactive care, better use of our hospitals and a new approach to responding in a crisis. These are supported by improvements to our support for our workforce, use of digital and technology, financial joint working, use of our estates and making best use of our purchasing power as major institutions in the city to bring better social benefits.

3.3 The Leeds Health and Care Plan (Appendix 2) has been further developed following feedback from Community Committees.

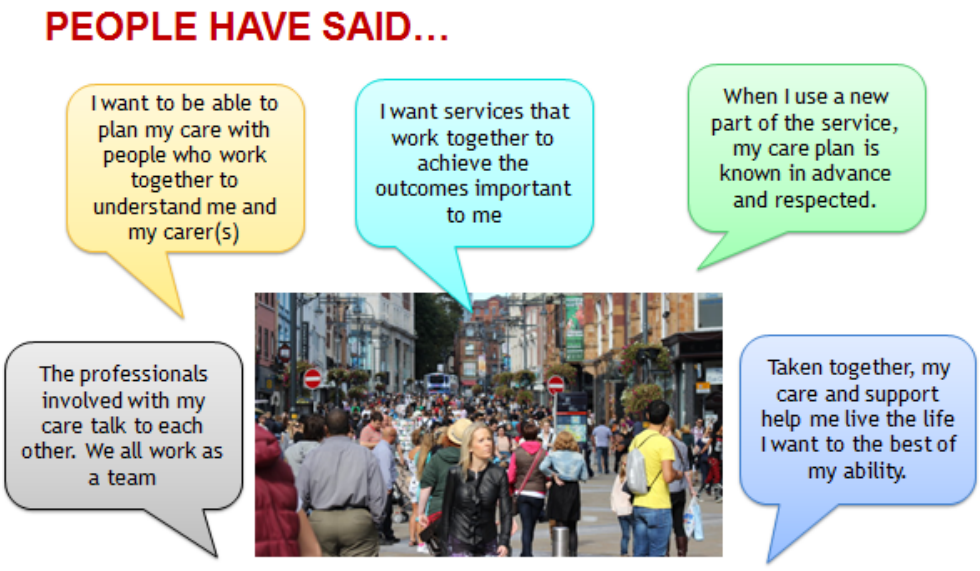
3.4 The Leeds Plan conversation has been supported by partners and stakeholders from across various health and care providers and commissioners, as well as Healthwatch and Youthwatch Leeds, Third Sector in addition to local area Community Committees. Discussion at Leeds City Council Executive Board on July 2017 endorsed the overall approach for further conversation with the public. Refinement of the Leeds Health and Care Plan has continued through the Leeds Health and Wellbeing Board meetings on the 20th June 2017 and 28th of September 2017, and through the Scrutiny Board (Adults and Health) meeting on the 5th of September. Using the feedback received the Leeds Health and Care Plan has been updated as detailed below as Background Information.

## 4. How does the Plan affect local community services?

4.1 The Leeds Plan is an ambitious set of actions to improve health and care in Leeds and to close our three gaps. It requires a new approach to working with people, inspiring change through better conversations and a move towards much more community based care. To achieve this the Plan includes a significant change to the way our health and care services work, particularly those based in the community.

Community Committee and other public feedback has said that health and care is often not working because:

- They have to wait a long time between services and sometimes they get forgotten, or they worry that they might have been forgotten.
- The health and care system is complicated and it can be difficult to know who to go to for what. This causes stress for services users and carers because there is often no-one who can provide everything they need.
- People feel as though they are being 'passed around' and they often end up having to tell their story again and again. No-one seems to ask what's most important to them so they feel as though they have to accept what's on offer and what they are told to do.
- Service users and carers value and respect staff and services highly and are thankful that they have health and care available to them. They don't want to complain or be seen as a nuisance as they know how over-burdened workers are.



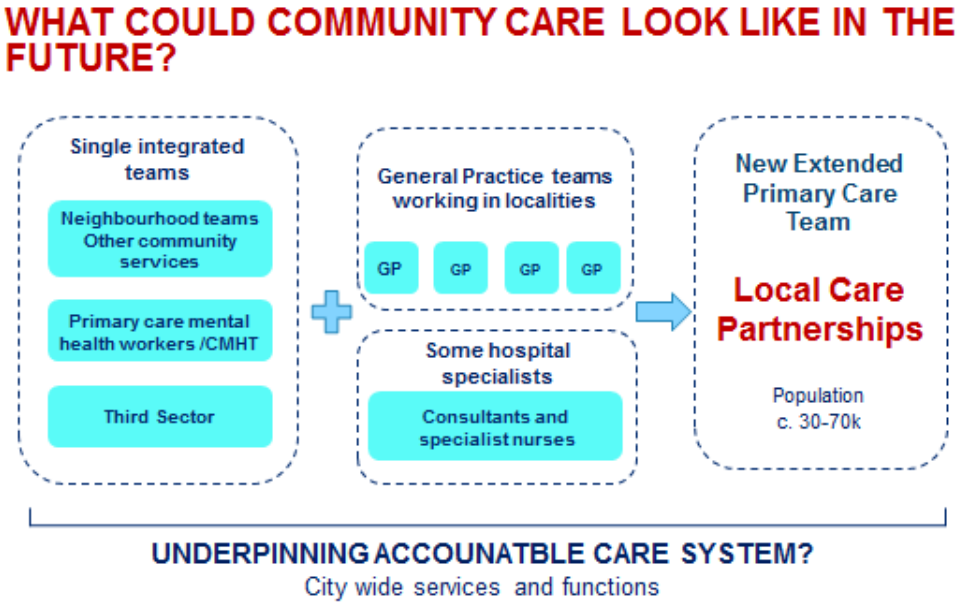
4.2 The starting point to changes in Leeds is the already established pioneering integrated health and social care teams linked to thirteen neighbourhoods (Integrated Neighbourhood Teams). This means that the basis of joint working between community nursing and social workers and other professionals as one team for people in a locality is already in place.

4.3 We have an opportunity to build on this way of working and increase the number of services offered in a neighbourhood team. In order to make this happen we are agreeing with partners what this team may look like and then ensure the organisations that plan and buy health and care services align or join their planning and budgets so that we both create these teams and avoid duplication and gaps in care. This will ensure resources are all focused on making health and care better, simpler and better value.


4.4 The plan is for the number of services based around neighbourhoods to increase and jointly work together as Local Care Partnerships. Building on the current neighbourhood teams Local Care Partnerships will include community based health and care services and possibly some services that are currently provided in hospital such as some outpatient appointments. People will still be registered with their GP practice and the vision is that a much wider range of health and care services will 'wrap-around' in a new way of working that emphasises team working to offer greater capacity than the GP alone. It will mean services no longer operating as entirely separate teams as they often do now.

4.5 Professionals working within Local Care Partnerships will work as one team avoiding the need for traditional referrals between services. The approach will be locally tailored to acknowledge how health and care needs vary significantly across Leeds. Working with local people, professionals within Local Care Partnerships will have more opportunities to respond to the needs of local populations and focus on what matters most for local communities.

4.6 The ambition is for the majority of peoples' needs will be met by a single team in their local area in the future making services easier to access and coordinate. If people do need to go into hospital the services will work together to make sure this happens smoothly.




4.7 These changes will take a number of years to work towards and people are unlikely to start to see any changes until 2019-20 at the earliest. Before this point we will work with local people and stakeholders to make sure the model will deliver what people need.

## 5. A Conversation with Citizens

5.1 In order to progress the thinking and partnership working that has been done to help inform the Leeds Health and Care Plan to date, the next stage is to begin a broader conversation with citizens in communities. The conversation we would like to have will be focussed on the ideas and direction of travel outlined in the Leeds Health and Care Plan and the changes proposed to integrate our system of community services. We wish to ask citizens and communities what community strengths already exist for health and care, what they think about the updated plan and ideas to change community services and how they wish to continue to be involved. We are inviting comment and thoughts on these.

5.2 Our preparation for our conversation with citizens about plans for the future of health and care in Leeds will be reflective of the rich diversity of the city, and mindful of the need to engage with all communities. Any future changes in service provision arising from this work will be subject to equality impact assessments and plans will be developed for formal engagement and/or consultation in line with existing guidance and best practice.

5.3 Over the coming weeks, engagement will occur through a number of local and city mechanisms outlined below in addition to Community Committee meetings. Where engagements occur this will be through a partnership approach involving appropriate representation from across the health and care partnership.

- Staff *engagement- November / December.* Staff will be engaged through briefings, newsletters, team meetings, etc. All staff will have access to a tailored Leeds Plan briefing and online access to the Leeds Plan and Narrative.

- *'Working Voices' engagement - November*
  We will work with Voluntary Action Leeds (VAL) to deliver a programme of engagement with working age adults, via the workplace.

- *Third Sector engagement events - November*
  We will work with Forum Central Leeds to deliver a workshop(s) to encourage and facilitate participation and involvement from the third sector in Leeds in the discussion about the Leeds Plan and the future of health and care in the city.

- *'Engaging Voices' Focus Groups, targeted at Equalities Act 'protected Characteristic Groups - November*
  We will work with VAL to utilise the 'Engaging Voices' programme of Asset Based Engagement to ensure that we encourage participation and discussion from seldom heard communities and to consider views from people across the 'protected characteristic' groups under the Equalities Act.

- *3 public events across city – January / February*
  Working with Leeds Involving People (LIP) we will deliver a series of events in each of the Neighbourhood Team areas for citizens to attend and find out more about the future of health and care in Leeds. These will be in the style of public exhibition events, with representation and information from each of the 'Programmes' within the Leeds Plan and some of the 'Enablers'. To maximise the benefit of these events, they will also promote messages and services linked to winter resilience and other health promotion / healthy living and wellbeing services.

- *'Deliberative' Event – early in the New Year*
  We will use market research techniques to recruit a demographically representative group of the Leeds population to work with us to design how a Local Care Partnership should work in practice and to find out what people's concerns and questions are so we can build this into further plans.

5.4 The plan and narrative will be available through our public website 'Inspiring Change' (www.inspiringchangeleeds.org) where citizens will be able to both read the plan, ask questions and give their views. Collated feedback from the above conversations will provide the basis for amendments to the Plan actions and support our next stages of our Plan development and implementation.

5.5 Through engagement activities we will build up a database of people who wish to remain involved and informed. We will write to these people with updates on progress and feedback to them how their involvement has contributed to plans. We will also provide updates on the website above so that this information can be accessed by members of the public.

## 6. Corporate considerations

### 6.1 Consultation, engagement

6.1.1 A key component of the development and delivery of the Leeds Health and Care Plan is ensuring consultation, engagement and hearing citizen voice. The approach to be taken has been outlined above.

### 6.2 Equality and diversity / cohesion and integration

6.2.1 Any future changes in service provision arising from this work will be subject to an equality impact assessment.

6.2.2 Consultations on the Leeds Health and Care Plan have included diverse localities and user groups including those with a disability.

### 6.3 Resources and value for money

6.3.1 The Joint Strategic Needs Assessment (JSNA) and the Leeds Health and Wellbeing Strategy 2016-2021 have been used to inform the development of the Leeds Health and Care Plan. The Leeds Health and Wellbeing Strategy 2016-2021 remains the primary document that describes how we improve health in Leeds. It is rooted in an understanding that good health is generated by factors such as economic growth, social mobility, housing, income, parenting, family and community. This paper outlines how the emerging Plan will deliver significant parts of the Leeds Health and Wellbeing Strategy 2016-2021 as they relate to health and care services and access to these services.

6.3.2 There are significant financial challenges for health and social care both locally and nationally. If current services continued unchanged, the gap estimated to exist between forecast growth in the cost of services, growth in demand and future budgets exceeds £700m at the end of the planning period (2021). The Leeds Health and Care Plan is designed to address this gap and is a significant step towards meeting this challenge and ensuring a financially sustainable model of health and care.

6.3.3 The Leeds Health and Care Plan will directly contribute towards achieving the breakthrough projects: ‘Early intervention and reducing health inequalities’ and ‘Making Leeds the best place to grow old in’. The Plan will link to local breakthrough project actions for example in targeting localities for a more ‘Active Leeds’.

6.3.4 The Leeds Health and Care Plan will also contribute to achieving the following Best Council Plan Priorities: ‘Supporting children to have the best start in life’; ‘preventing people dying early’; ‘promoting physical activity’; ‘building capacity for individuals to withstand or recover from illness’, and ‘supporting healthy ageing’.

### 6.4 Legal Implications, access to information and call In

6.4.1 There are no access to information and call-in implications arising from this report.

### 6.5 Risk management

6.5.1 Failure to have robust plans in place to address the gaps identified as part of the Leeds Health and Care Plan development will impact the sustainability of the health and care in the city.

6.5.2 The proposed model of health based on local health and care partnerships requires support both from communities and the complex picture of local and regional health and social care systems and their interdependencies. Each of the partners has their own internal pressures and governance processes they need to follow.

6.5.3 Ability to release expenditure from existing commitments without de-stabilising the system in the short-term will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.

6.5.4 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on developing and delivering a robust Leeds Health and Care Plan within an effective governance framework.

## 7. Conclusion

7.1 The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).

7.2 The Plan has been developed and improved through working with citizens, third sector groups, a variety of provider forums and through our democratic and partnership governance.

7.3 The Leeds Plan envisages a significant move towards a more community focused approach, which understands that good health is a function of wider factors such as housing, employment, environment, family and community and is integral to good economic growth.

7.4 The Plan includes a significant change to how health care is organised in communities to bring together current resources into cohesive Local Care Partnerships.

## 8. Recommendations

The Community Committee is recommended to:

- Support the updated Leeds Plan as a basis for conversation with citizens on the future of health and care.
- Actively support widespread conversation and discussion of the Leeds Plan and narrative to encourage feedback and comment.
- Support the emerging model of Local Care Partnerships and actively engage with their development in their communities.

## Background information

| Community Committee Feedback Spring 2017 | Action taken |
|---|---|
| **Committees emphasised these areas for the Plan to address:**<br><br>**Mental health**<br>**Physical activity**<br>**Drug & Alcohol Services**<br>**Diet and nutrition, especially for mothers and children**<br>**Tackling loneliness**<br>**Getting into schools more and promoting healthy lifestyles from a young age**<br>**Better integration**<br>**Relieve pressure on hospitals and GPs by making better use of pharmacies and nurses in communities**<br>**The number of GPs in the city and the consistency of good quality GP and health services across the city.** | The Plan draft promotes holistic inclusive health with mental health needs considered throughout health and care services. There are specific actions for those with a need for mental health care in hospital and actions to promote wellbeing through physical activity. The Plan targets people with frailty for a more integrated approach where loneliness and mental health will be addressed in a more joined up approach locally by health and care services. The Plan links to actions across West Yorkshire to improve mental health.<br><br>Physical activity, Drug and Alcohol, A best start (including nutrition advice and early promotion of health lifestyles) are actions in the Plan.<br><br>The integration approach across the Plan emphasizes better use of all community resources including nurses and pharmacists in a team approach to support GPs and hospital services.<br><br>The workforce plans in the city are to increase the numbers in training of GPs and nurses in line with NHS national strategies. This increase would need to be balanced against the number of trend of more GPs working part time and retiring. Our plan is to increase the skills and numbers of other staff in nursing and primary care team roles to improve access to healthcare. This is being undertaken in a citywide approach to ensure consistent quality of health services accessible by local communities. |
| **Committees felt the following were important to working with citizens in a meaningful, open and honest way:**<br>**Health system is very complex – if we can simplify it this would benefit local people**<br>**Reassurance / education / coaching for people with long-term conditions so they feel more empowered to manage their condition better and reduce the need to go to the hospital or GP**<br>**People recognised the need to do things differently in a landscape of reducing resources, but felt there needed to be greater transparency of the savings needed and their impact on services** | The Plan has tried to keep a simple approach to how the health care system works and contains improvements for greater simplicity. The Plan is for local services to be more joined together with less referrals leading to appointments with different organisations in different places.<br><br>The Plan includes specific approaches to reassurance, education and coaching for long term conditions to increase empowerment and reduce GP and hospital use<br><br>The wider plan document includes information transparently of current estimates of savings that need to be made and the risks to services that may become real. |
| **The following were requests by Committees for further involvement:**<br>**There should be more regular discussions about health locally**<br>**Local Community Health Champions**<br>**Local workshops, including at ward level**<br>**People want to better understand their local health and wellbeing gaps and be empowered to provide local solutions and promote early prevention / intervention** | The Plan has adopted a conversations with Community Committees and other local conversations as key to its approach. Local Health Champions are integral to these and increasing use is being made of local workshops and ongoing meetings to<br>The proposal of a move to Local Care Partnerships is to change the role and model of primary care and integrates local leadership from elected members, health services, local third sector organisations and education to promote early prevention and better early intervention. |

| Leeds Health and Wellbeing Board and Scrutiny Board feedback 2017 | Action taken |
|---|---|
| **Acknowledged and welcomed the opportunity for the Community Committees to have had early discussions on the Leeds Health and Care Plan during the Spring 2017. A request for an update to the community committees was noted.** | The success of these sessions have been held up as a good practice example across the region of the value of working 'with' elected members and our local communities. We recognise that an ongoing conversation with elected members is key to this building on the sessions that took place.<br><br>In addition to local ongoing conversations since Spring 2017, there are a number of engagement opportunities with elected members outlined throughout the report under para 3.6 including a second round of Community Committee discussions taking place during autumn/winter. |
| **The need to emphasise the value of the Leeds Pound to the Health and Care sector and the need to acknowledge that parts of the health economy relied on service users not just as patients but buyers.** | There is a greater emphasis to the Leeds Pound within the narrative document and it is now highlighted within the Leeds Health and Care Plan on a page through "Using our collective buying power to get the best value for our 'Leeds £". |
| **Emphasising the role of feedback in shaping the finished document.** | The narrative in its introduction emphasises the engagement that has taken place to shape the document from conversations with patients, citizens, doctors, health leaders, voluntary groups and local elected members. The narrative also invites staff and citizens to provide feedback through various forums and mechanisms. Further work is needed to make this process easier and this will take place during October/November. |
| **A review of the language and phrasing to ensure a plain English approach and to avoid inadvertently suggesting that areas of change have already been decided.** | The narrative has been amended for plain English and emphasises the importance of ongoing engagement and co-production to shape the future direction of health and care in the city. |
| **The narrative to also clarify who will make decisions in the future** | The narrative makes greater reference to decision making in 'Chapter 10: What happens next?' highlighting that:<br>• The planning of changes will be done in a much more joined up way through greater joint working between all partners involved with health and care partners, staff and citizens.<br>• Significant decisions will be discussed and planned through the Health and Wellbeing Board.<br>• Decision making however will remain in the formal bodies that have legal responsibilities for services in each of the individual health and care organisations. |
| **The Plan to include case studies. Acknowledged the need to broaden the scope of the Plan in order to "if we do this, then this how good our health and care services could be" and to provide more detail on what provision may look like in the future.** | Case studies are being co-produced with citizens and staff groups which will describe their experience now and how this should look in the future. These will be incorporated in the future iteration of the Plan as well as used in engagement sessions with communities. |

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|---|---|
| **References to the role of the Leeds Health and Wellbeing Board and the Leeds Health and Wellbeing Strategy 2016-2021 to be strengthened and appear earlier in the Plan.** | The narrative in its introduction and throughout the document emphasises the role of the Leeds Health and Wellbeing Board. It also articulates that the Leeds Health and Care Plan is a description of what health and care will look like in the future and that it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. |
| **References to taking self-responsibility for health should also include urgent care/out of hospital health** | Narrative has been updated to reflect this. In addition, the engagement through the autumn will be joined up around Leeds Plan, plans for winter and urgent care. |
| **Assurance was sought that the Plan would be co-produced as part of the ongoing conversation** | Plans outlined in this paper for ongoing conversation and co-production during the autumn. |
| **A focus on Leeds figures rather than national** | Work is ongoing with finance and performance colleagues and will feed into the engagement through the autumn. |
| **Requested that a follow up paper with more detail, including the extended primary care model, be brought back in September.** | The narrative has a greater emphasis on the transition towards a community focused model of health and is highlighted on the Leeds Health and Care Plan on a Page. A separate update on the System Integration will be considered by the Board on 28 September 2017. |
| **Request that pharmacy services are included as part of the Leeds Plan conversations** | Pharmacy services will be engaged in the Plan conversation with citizens via their networks. The opportunity has been taken to also include dental and optometry networks. |
| **The need to be clear about the financial challenges faced and the impact on communities.** | The Narrative contains clear information of a financial gap calculated for the city. The narrative contains a list of clear risks to the current system of healthcare posed by the combination of funding, arising need and need for reform.<br><br>The presentation that accompanies the plan has been amended in light of Scrutiny comments to be clearer on the reality of financial challenges. This presentation will be used for future public events. |
| **Clarification sought in the report regarding anticipated future spending on the health and care system in Leeds.** | Scrutiny identified that the previous information in the narrative indicated the balance of expenditure would fund greater volume of community based care but also seemed to portray a significant growth in total expenditure. This diagram has been replaced by a 'Leeds Left Shift' diagram indicating more clearly the shift in healthcare resources without indicating significant growth. |
| **An update on development of a communication strategy and ensuring that the public was aware about how to access information on-line.** | This paper identifies a communication approach for the Leeds Plan and Narrative. |
| **Suggested amendments to patient participation and the role of Healthwatch Leeds.** | The section on participation is being revised to include the opportunities and approach identified by Healthwatch Leeds. |

**Appendix 1 - Draft Area overview profile for Armley and Pudsey Integrated Neighbourhood Team (INTs)**

The Leeds public health intelligence team produce public health profiles at various local geographies Middle Layer Super Output Area, Ward and Community Committee.

These are available on the Leeds Observatory (http://observatory.leeds.gov.uk/Leeds_Health/). In addition, the public health intelligence team have developed profiles for Integrated Neighbourhood Teams (INTs). There are 13 in Leeds, each team is a group of health and social care staff built around localities in Leeds to deliver care tailored to the needs of an individual. Further information on services delivered through integrated neighbourhood teams is available here https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/neighbourhood-teams/. People who need care from these teams are allocated to a team based on their GP practice, we have combined GP practice level information to produce a profile for each of the 13 integrated neighbourhood teams in Leeds.

Key messages from the profiles are highlighted below:

**Armley INT**

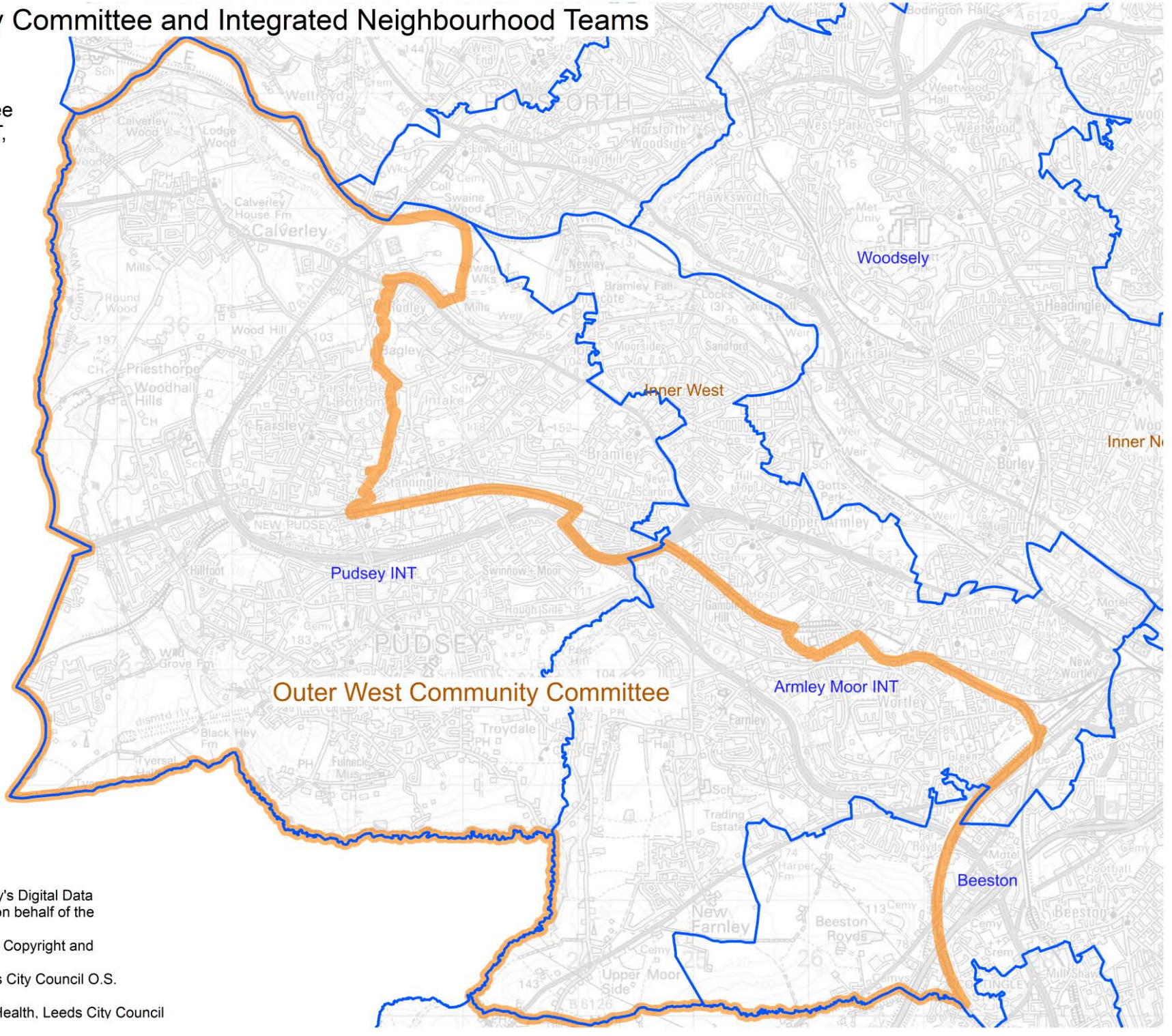
- One in three of the population live within the most deprived 5th of Leeds, the remaining majority live within the 2nd most deprived 5th.
- Child obesity in year 6 is 2nd highest in the city, reception obesity not far behind.
- This INT overlaps two children's clusters with very low primary school achievement, one cluster has the lowest rate in the city.
- NEET (Young people not in education, employment or training) rates are very high in clusters that overlap this INT.
- Adult smoking and obesity are 2nd and 1st highest in the city with all practice rates above Leeds averages.
- GP recorded conditions are significantly higher than Leeds rates except cancer which is joint lowest (low screening uptake and higher death rates are seen in more deprived areas).
- All cause mortality for under 75s is significantly above Leeds, female rates are not falling as fast as male rates.
- Circulatory mortality rates show male rates falling fast but females static.

**Pudsey INT**

- Similar population structure to Leeds but without the student and young adult age band bulge.
- Slightly larger 'White British' ethnic group proportion than Leeds.
- One of the most deprived children's clusters in Leeds overlaps this INT footprint and has the worst primary school achievement rates in the city.
- GP recorded Obesity and cancer are significantly higher than Leeds rates.
- This INT has the highest rate of GP recorded common mental health issues in the city.
- Social isolation scores vary widely from some of the very highest to very lowest.
- General mortality rates are around Leeds rates, but male and female rates are very different with male rates for circulatory diseases mortality being significantly above Leeds and female rates significantly below.

# Outer West Community Committee and Integrated Neighbourhood Teams

Outer West Community Committee intersects most of the Pudsey INT, with the remaining Community Committee residential area being covered by the Armley Moor INT





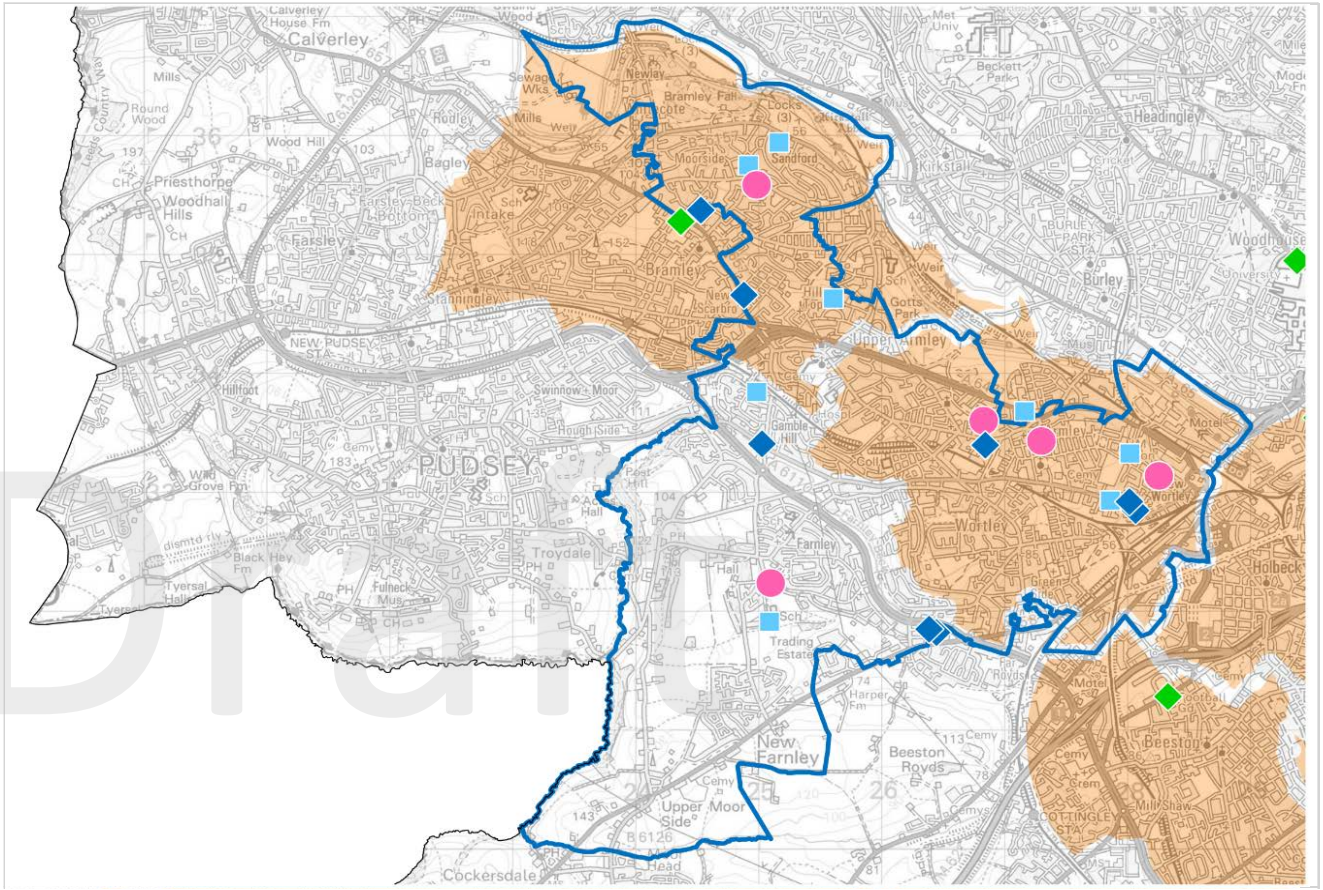
Adam Taylor, Office of the Director of Public Health, Leeds City Council

# Area overview profile for Armley Integrated Neighbourhood Team

November 2017

This profile presents a high level summary using practice membership data. In a small number of cases practices and branches are members of different INTs, to account for this their patient data is allocated to the INT their nearest branch belongs to. Where data is not available at practice level it is aggregated to INT footprint on a purely geographical basis.

Space kept free for bullet point key messages from stakeholder engagement




Practices with more than one branch in this INT are listed once here and appear multiple times in the map: Armley Medical Practice. Manor Park Surgery. Priory View Medical Centre. Thornton Medical Centre. Whitehall Surgery. The Highfield Medical Centre. Beechtree Medical Centre. Hawthorn Surgery.

Note: A small number of practices have branches that are far enough apart to fall into different INTs. These practices are not listed here or shown in the map. The original INT boundaries do not relate to statistical geographies and so this footprint which is a nearest match LSOA area is used when aggregating geographical data.

INT footprint boundary

Most deprived 5 Children's Clusters

GP practice - member of INT

Children's centre within INT footprint

Community Health Development venue

Voluntary Community Sector venue

# Area overview profile for Armley Integrated Neighbourhood Team

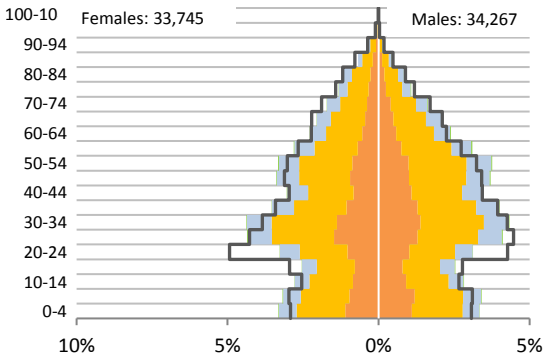
This profile presents a high level summary of data for the Armley Integrated Neighbourhood Team (INT), using practice membership data. In a small number of cases, practices and branches are members of different INTs, to account for this, their patient data is allocated to the INT their nearest branch belongs to. Where data is not available at practice level it is aggregated to INT footprint on a purely geographical basis ⚡.

All INTs are ranked to display variation across Leeds and this one is outlined in blue. Practices belonging to this INT are shown as individual blue dots. Actual counts are shown in blue text. Leeds overall is shown as dark grey, the most deprived fifth of Leeds** is shown in orange.

Where possible, INTs are colour coded red or green if rates are significantly worse or better than Leeds.

## Population: 68,012 in April 2017 *GP data*

Comparison of INT and Leeds age structures. Leeds is outlined in black, INT populations are shown as dark and light orange if resident inside the 1st or 2nd most deprived fifth of Leeds, and green if in the least deprived.

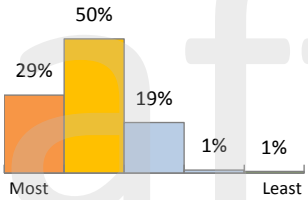



| GP recorded ethnicity, top 5 | % INT | % Leeds |
|---|---|---|
| White British | 66% | 62% |
| Other White Background | 9% | 9% |
| Not Recorded | 8% | 6% |
| Not Stated | 8% | 2% |
| Black African | 2% | 3% |

*(April 2017)*

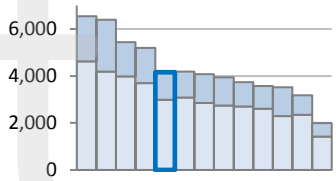
## Deprivation distribution

Proportions of INT within each deprivation fifth of Leeds April 2017. Leeds has equal proportions. **




## Aged 74+ *(April 2017)*

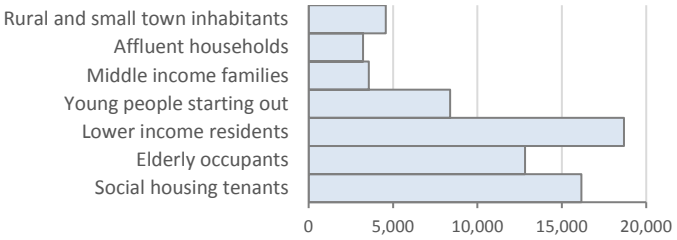
INTs ranked by number of patients aged over 74. 74y-84y in dark green, 85y and older in light green.




## Mosaic Groups in this INT population *(October 2017)*

The INT population as it falls into Mosaic population segment groups. These are counts of INT registered patients who have been allocated a Mosaic type using location data in October 2017.

http://www.segmentationportal.com



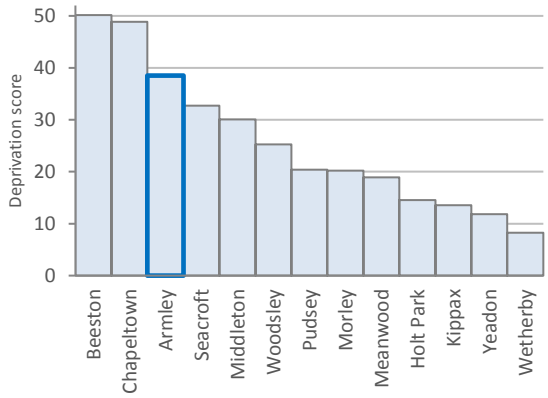

## Population counts in ten year age bands for each INT *(April 2017)*

| | Woodsley | Chapeltown | Meanwood | Middleton | Seacroft | Armley | Yeadon | Pudsey | Beeston | Morley | Holt Park | Kippax | Wetherby |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 80+ | 2,266 | 2,103 | 4,224 | 3,185 | 3,976 | 2,521 | 3,119 | 2,465 | 1,198 | 1,804 | 2,455 | 2,392 | 2,220 |
| 70-79 | 3,066 | 3,249 | 5,265 | 5,341 | 5,933 | 3,907 | 5,111 | 3,778 | 1,830 | 3,438 | 3,431 | 4,320 | 3,754 |
| 60-69 | 5,028 | 5,569 | 8,194 | 7,550 | 8,094 | 6,016 | 7,053 | 5,489 | 3,023 | 4,713 | 4,591 | 4,986 | 4,128 |
| 50-59 | 6,802 | 9,376 | 10,627 | 10,747 | 10,471 | 8,843 | 8,182 | 6,979 | 4,799 | 6,151 | 5,431 | 5,728 | 4,469 |
| 40-49 | 8,717 | 13,132 | 12,437 | 11,412 | 10,251 | 9,257 | 8,319 | 7,734 | 6,123 | 6,499 | 5,692 | 5,656 | 4,141 |
| 30-39 | 17,473 | 20,275 | 14,961 | 12,099 | 10,462 | 11,065 | 7,156 | 8,386 | 8,130 | 6,610 | 6,307 | 4,886 | 3,099 |
| 20-29 | 53,913 | 20,411 | 10,616 | 10,372 | 10,107 | 10,101 | 5,665 | 6,427 | 6,945 | 5,286 | 5,116 | 4,474 | 2,448 |
| 10-19 | 13,339 | 11,955 | 8,778 | 9,119 | 9,000 | 7,281 | 6,128 | 5,406 | 5,244 | 4,418 | 4,408 | 4,274 | 3,050 |
| 00-09 | 7,297 | 15,190 | 11,384 | 11,179 | 9,970 | 9,021 | 6,358 | 6,995 | 6,800 | 5,130 | 5,313 | 4,322 | 3,067 |
| Total | 117,901 | 101,260 | 86,486 | 81,004 | 78,264 | 68,012 | 57,091 | 53,659 | 44,092 | 44,049 | 42,744 | 41,038 | 30,376 |

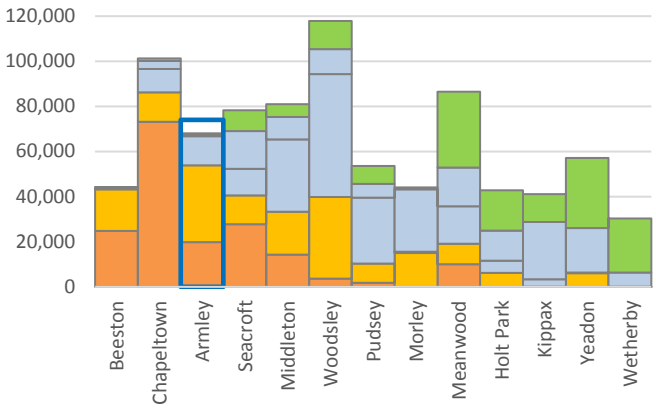
## Deprivation and the population of Armley INT *IMD2015 and GP data*

The INT deprivation score is calculated using the count and locations of patients registered with member practices in April 2017, and the Index of Multiple Deprivation 2015 (IMD). The larger the deprivation score, the more prominent the deprivation within the INT population. This INT deprivation score is 38.5, ranked number 3 in Leeds.

### INTs ranked by deprivation *score*




### INT population *sizes* ranked by deprivation score

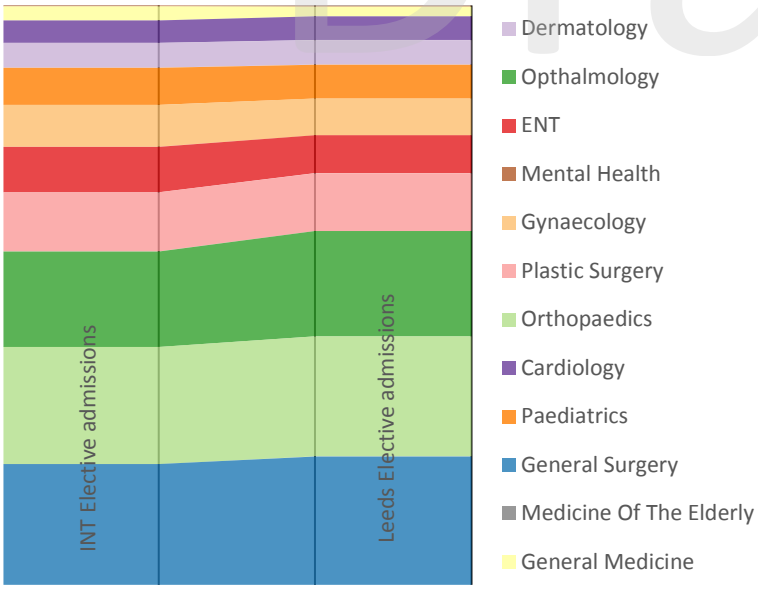



## Hospital admissions for this INT by specialty (2016/17)

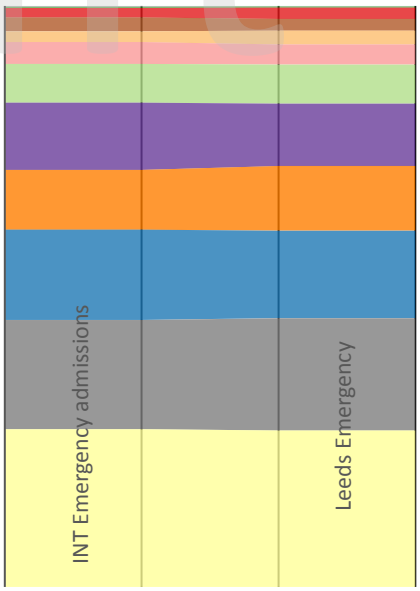
Elective (non-emergency) and emergency admission proportions for this INT are compared to Leeds below. Admissions data is divided between twelve hospital specialties and the additional group of 'others' which is where an admission does not have a recognised specialty assigned to it.

Non-emergency and emergency admission patterns obviously differ significantly, but of interest here is how the INT might differ to Leeds overall. The two charts us the same colour coding and both rank specialties by their contribution to Leeds overall, (the 'others' group is not charted or included in top 5 lists)

### Proportions of Elective admissions. INT vs Leeds




### Proportions of Emergency admissions. INT vs Leeds

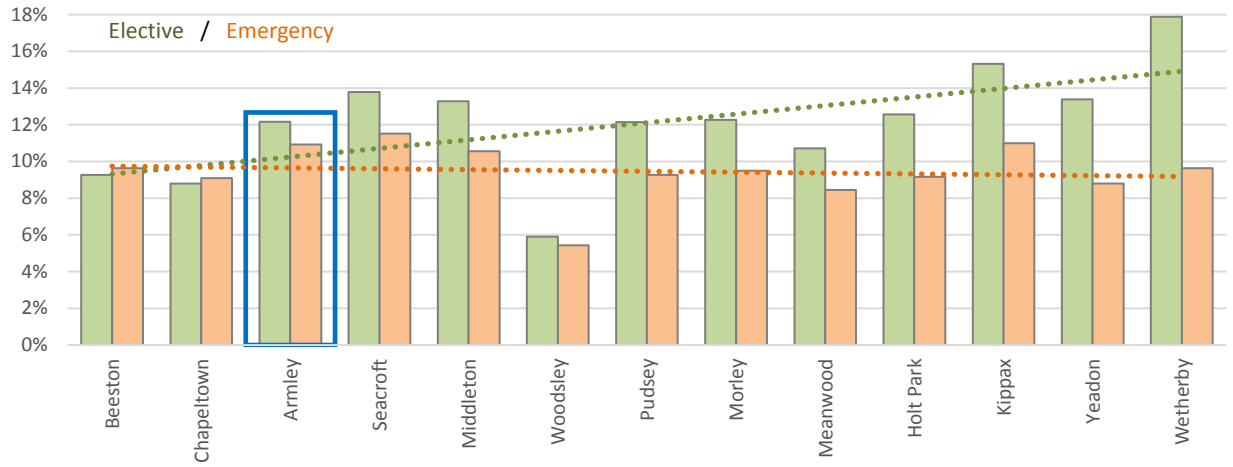



| INT Elective admissions top 5 | *% of INT admissions* | *Leeds proportion* |
|---|---|---|
| 1st General Surgery | *12%* | 12% |
| 2nd Orthopaedics | *11%* | 11% |
| 3rd Opthalmology | *9%* | 10% |
| 4th Plastic Surgery | *6%* | 5% |
| 5th ENT | *4%* | 4% |

| INT Emergency admissions top 5 | *% of INT admissions* | *Leeds proportion* |
|---|---|---|
| 1st General Medicine | *16%* | *16%* |
| 2nd Medicine Of The Elderly | *11%* | *12%* |
| 3rd General Surgery | *9%* | *9%* |
| 4th Cardiology | *7%* | *7%* |
| 5th Paediatrics | *6%* | *7%* |

## Elective and emergency admission *rates* and deprivation

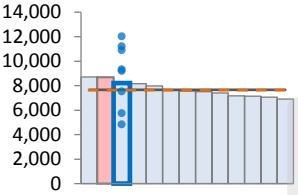
Hospital admission rates as percentage of whole INT populations. The INTs are *ordered by deprivation score* and there is a clear increase in proportion of elective admissions (green) as INTs become less deprived. Emergency admissions show a slightly inverted relationship with deprivation at INT level.




*Numerator: Count of all admissions. Denominator: Oct 2016 Leeds resident and registered population*

# Healthy children

## Asthma in children October 2016 (DSR per 100,000) *GP data*

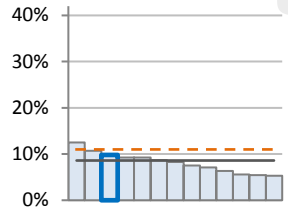



**Asthma - under 16s**

| | |
|---|---|
| INT | 8,211 |
| Leeds registered | 7,659 |
| Deprived fifth** | 7,633 |
| *INT count* | *935* |

*GP recorded* asthma in the under 16s, age standardised rates (DSR) per 100,000. Only the Seacroft INT asthma rate is significantly different to the Leeds rate.

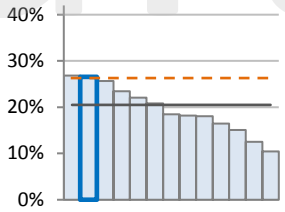
## Child obesity 2015-16 *NCMP, aggregated from LSOA to INT boundary*




**Obesity in Reception year**

| | |
|---|---|
| INT | 9.8% |
| Leeds registered | 8.6% |
| Deprived fifth** | 11.0% |

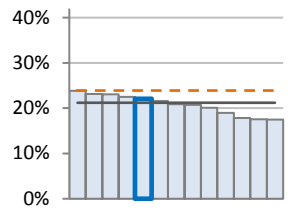
61 of 621 children in INT




**Obesity in Year 6**

| | |
|---|---|
| INT | 26.6% |
| Leeds registered | 20.5% |
| Deprived fifth** | 26.3% |

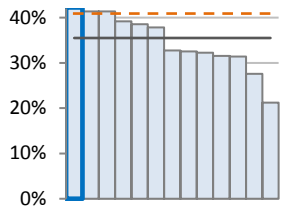
*137 of 516 children in INT*




**Obese *or* overweight, Reception year**

| | |
|---|---|
| INT | 21.9% |
| Leeds registered | 21.2% |
| Deprived fifth** | 23.9% |

*129 of 589 children*



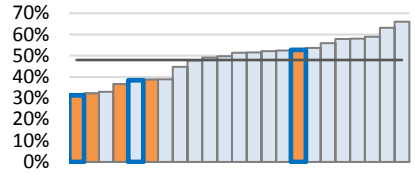

**Obese *or* overweight, Year 6**

| | |
|---|---|
| INT | 42.2% |
| Leeds registered | 35.5% |
| Deprived fifth** | 40.9% |

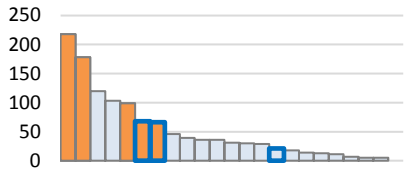
*218 of 516 children*

## Children's cluster data *Children and Young People's Plan Key Indicator Dashboard July 2017*

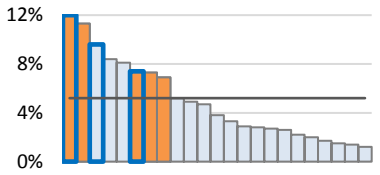
All 23 **Children's clusters** in Leeds, ranked below. Each INT footprint may be *overlapped* by one or more clusters and those having significant overlap with this INT are outlined in blue below. The five most deprived clusters in the city are shown in orange.




% with good achievement at the end of primary school (schools)

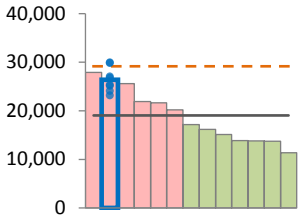



Looked after children



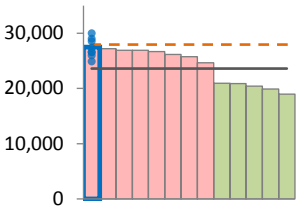

NEET - 'Not in education, employment or training'

## Healthy adults *GP data*




**Smoking (16y+)**

| | |
|---|---|
| INT | 26,406 |
| Leeds registered | 19,045 |
| Deprived fifth** | 29,163 |
| *INT count* | *15,046* |




**Obesity (BMI>30)**

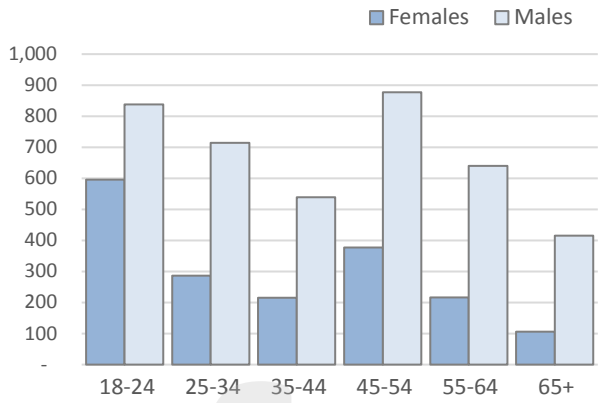
| | |
|---|---|
| INT | 27,499 |
| Leeds registered | 23,606 |
| Deprived fifth** | 27,951 |
| *INT count* | *13,248* |

(Within the population who have a recorded BMI)

## Audit-C alcohol dependency *GP data. Quarterly data collection, April 2017*

The Audit-C test assesses a patients drinking habits, assigning them a score. Patients scoring 8 or higher are considered to be at 'increasing risk' due to their alcohol consumption. In Leeds, almost half of the adult population have an Audit-C score recorded by a GP. Rates for age bands and females in Leeds are applied here to the INT registered population to form a picture of the alcohol risk in the whole INT adult population.

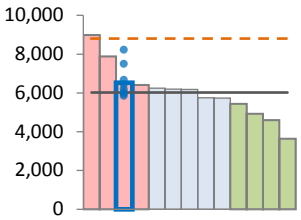
The table and chart below show the **predicted numbers of adults in this INT** registered population who would score 8 or higher.




| | 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|
| Females | 595 | 287 | 215 | 377 | 217 | 106 |
| Males | 838 | 714 | 539 | 878 | 640 | 415 |
| Persons | 1,383 | 989 | 745 | 1,242 | 846 | 533 |

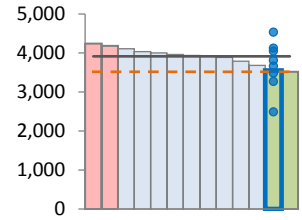
## Long term conditions, adults and older people *GP data*

GP data. Quarterly data collection, April 2017 (DSR per 100,000)



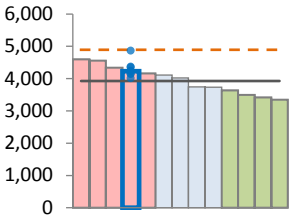

**Diabetes**

| | |
|---|---|
| INT | 6,528 |
| Leeds registered | 6,021 |
| Deprived fifth** | 8,802 |
| *INT count* | *3,577* |



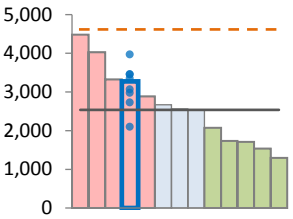

**Cancer** (January 2017)

| | |
|---|---|
| INT | 3,551 |
| Leeds registered | 3,915 |
| Deprived fifth** | 3,519 |
| *INT count* | *1,839* |




**CHD** (January 2017)

| | |
|---|---|
| INT | 4,229 |
| Leeds registered | 3,926 |
| Deprived fifth** | 4,894 |
| *INT count* | *2,130* |

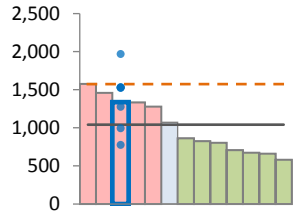



**COPD**

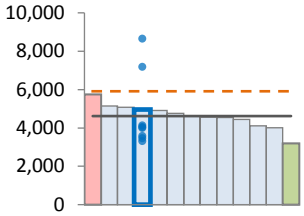
| | |
|---|---|
| INT | 3,275 |
| Leeds registered | 2,537 |
| Deprived fifth** | 4,617 |
| *INT count* | *1,680* |

## Long term conditions, adults and older people continued *GP data*

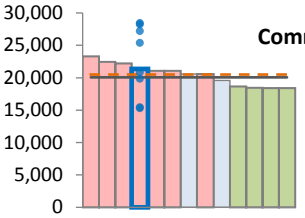
GP data. Quarterly data collection, (DSR per 100,000)




| **Severe mental heath** | (Jan '17) |
|---|---|
| INT | 1,338 |
| Leeds registered | 1,042 |
| Deprived fifth** | 1,574 |
| *INT count* | *850* |




| **Dementia (65+)** | Jan '17 |
|---|---|
| INT | 4,958 |
| Leeds registered | 4,618 |
| Deprived fifth** | 5,911 |
| *INT count* | *450* |




| **Common mental health** | (Jan '17) |
|---|---|
| INT | 21,385 |
| Leeds registered | 20,060 |
| Deprived fifth** | 20,496 |
| *INT count* | *13,828* |

The GP data charts show all 13 INTs in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. Where the INT is significantly above or below Leeds is it shaded red or green, if there is no significant difference then it is shown in blue. Blue circle indicators show rates for practices which are a member of the INT, in some instances scales are set which mean practices with extreme values are not seen.

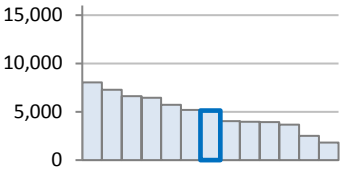
***Most deprived fifth, or quintile of Leeds - divides Leeds into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas. GP data only reflects those patients who visit their doctor, certain groups are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture.*



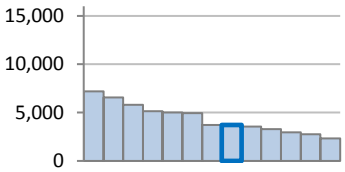
## Life limiting illness ⊁ *Census 2011, aggregated from MSOA to INT boundary*

INTs ranked by *number* of people reporting life limiting illness

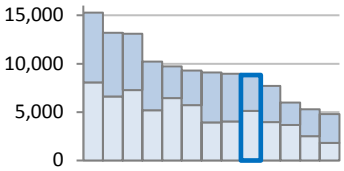
Life limiting illness, under 65



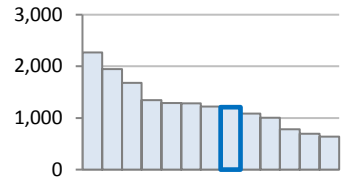

Life limiting illness, over 65



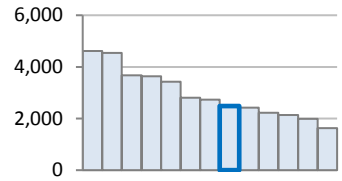

Life limiting illness all ages.
Under 65 years old in dark green. 65y and older in light green




## Carers providing 50+ hours care/week ⊁




## One person households aged 65+ ⊁




The number of people within the INT *area* in these categories are shown in the table below, the INT ranking position in Leeds is also shown.

⊁ This data is not related to INT practice membership so cannot be related back to practice membership of the INT. However each INT has a crude boundary allowing geographical data such as this to be allocated on that basis instead.

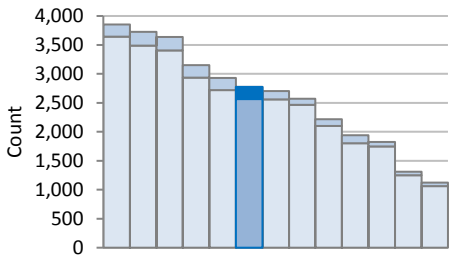
| | number | rank |
|---|---|---|
| Limiting Long Term Illness - All Ages | *8,821* | 9 |
| Limiting Long Term Illness - under 65 | *5,115* | 7 |
| Limiting Long Term Illness - 65+ | *3,706* | 8 |
| Providing 50+ hours care/week | *1,208* | 8 |
| One person households aged 65+ | *2,487* | 8 |

## People living with frailty and 'end of life'

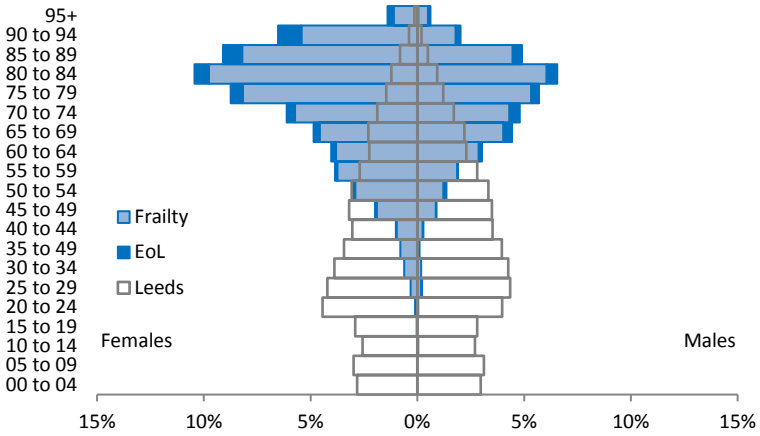
*Leeds data model September 2016 cohort*

Leeds Integrated Neighbourhood Teams ranked by combined count of End of Life and Frailty populations.

Total: 2,777. Frailty 2,564. End of life 213




INT (in blue) compared to Leeds by gender and age band.



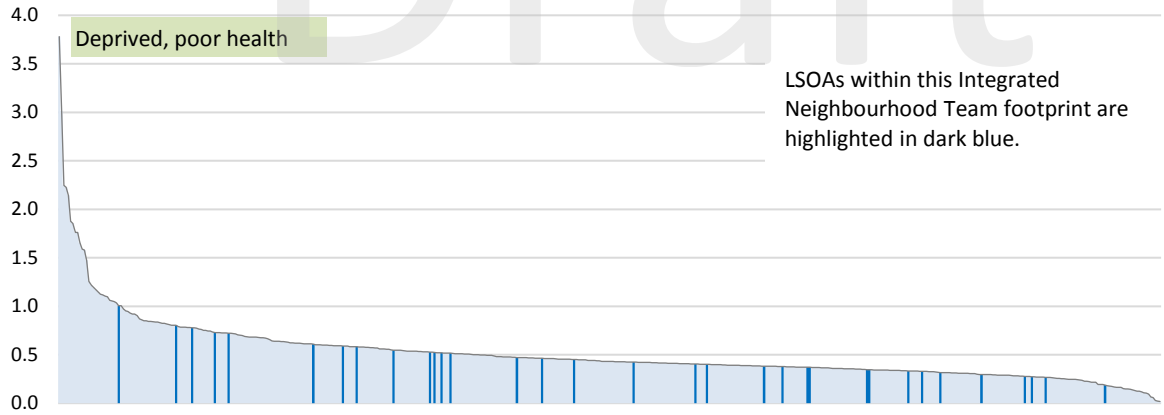

## Social Isolation Index ⊀

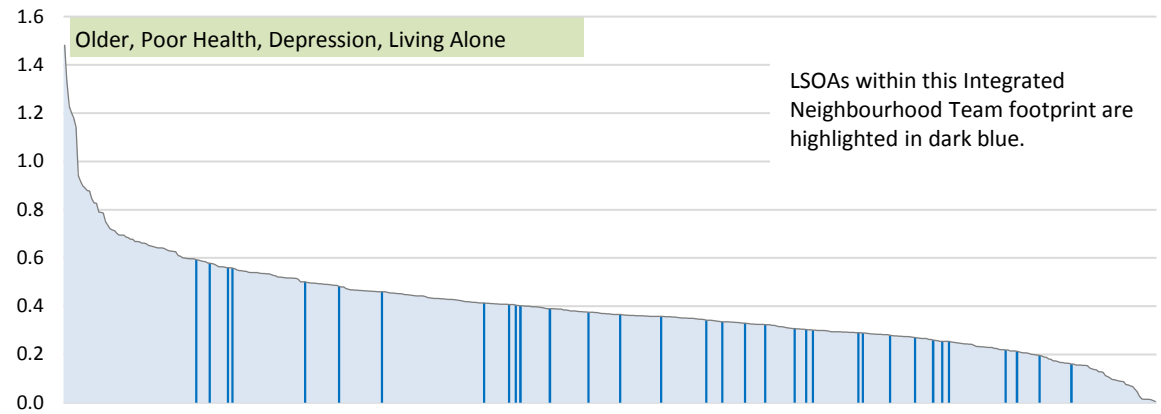
*LSOAs in INT footprint*

The Social Isolation Index visualises some of the broader determinants of health and social isolation as experienced by the older population. It brings together a range of indicators pulled from clinical, census and police sources. A shortlist was then used to generate population indexes, for two demographic groups across Leeds; 'Deprived, Poor Health' and 'Older, Poor Health, Depression, Living Alone'.

Each demographic group has a separate combination of indicators in order to better target the group characteristics, and variations in population sizes are removed during the index creation. The index levels show the likelihood a small area has of containing the demographic group in question. The higher the index score, the greater the probability that "at risk" demographics will be present, an area ranking 1st in Leeds is the most isolated in terms of that index. These charts show all Lower Super Output Areas (LSOAs) in Leeds, ranked by the indexes.






To find out more about the construction of the index, please contact James.Lodge@leeds.gov.uk

## Mortality, under 75s, age standardised rates per 100,000

*ONS and GP registered populations*

*"How different are the sexes in this INT"*

Males
Females
Persons

Shaded if significantly above Persons
Shaded if significantly below Persons

*"How different is this INT to Leeds"*

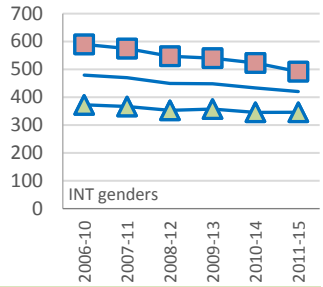
INT
Leeds
Deprived fifth of Leeds**

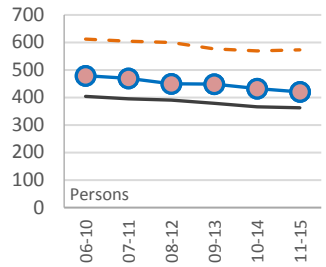
Shaded if significantly above Leeds
Shaded if significantly below Leeds

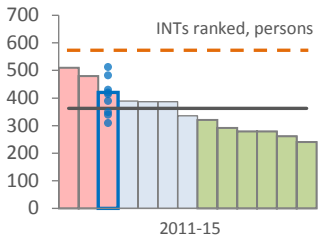
*"Where is this INT in relation to the others, and Leeds"*

INTs are ranked by the most recent rates and coloured as red or green if their rate is significantly above or below that of Leeds. Practice rates for those within this INT are shown as blue dots. This INT is highlighted with a blue border.

### All cause mortality

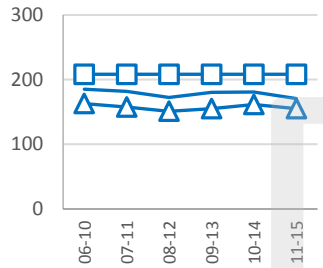


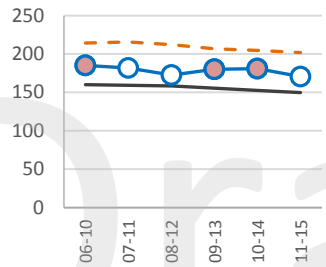



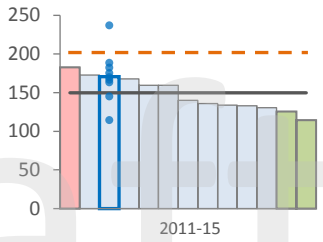




| Persons (DSR per 100,000) | |
|---|---|
| INT | 420 |
| Leeds resident | 363 |
| Deprived fifth** | 573 |
| *INT count* | *989* |

### Cancer mortality

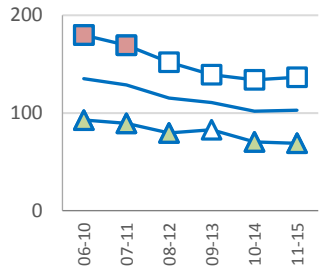


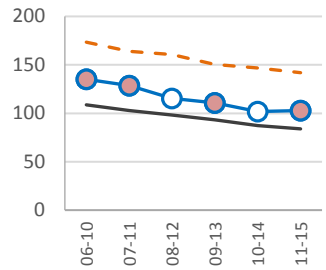



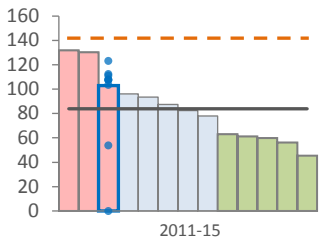




| Persons (DSR per 100,000) | |
|---|---|
| INT | 171 |
| Leeds resident | 150 |
| Deprived fifth** | 202 |
| *INT count* | *392* |

### Circulatory disease mortality

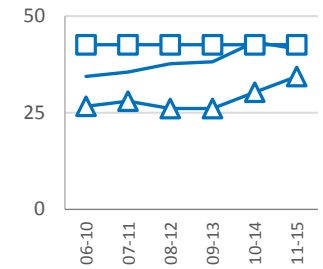


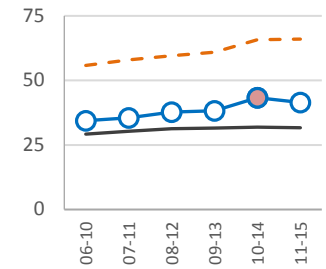



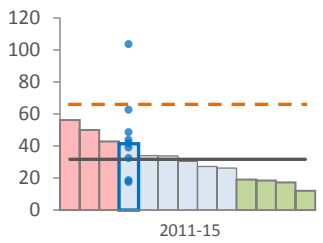




| Persons (DSR per 100,000) | |
|---|---|
| INT | 103 |
| Leeds resident | 84 |
| Deprived fifth** | 142 |
| *INT count* | *239* |

### Respiratory disease mortality




| Persons (DSR per 100,000) | |
|---|---|
| INT | 42 |
| Leeds resident | 32 |
| Deprived fifth** | 66 |
| *INT count* | *89* |

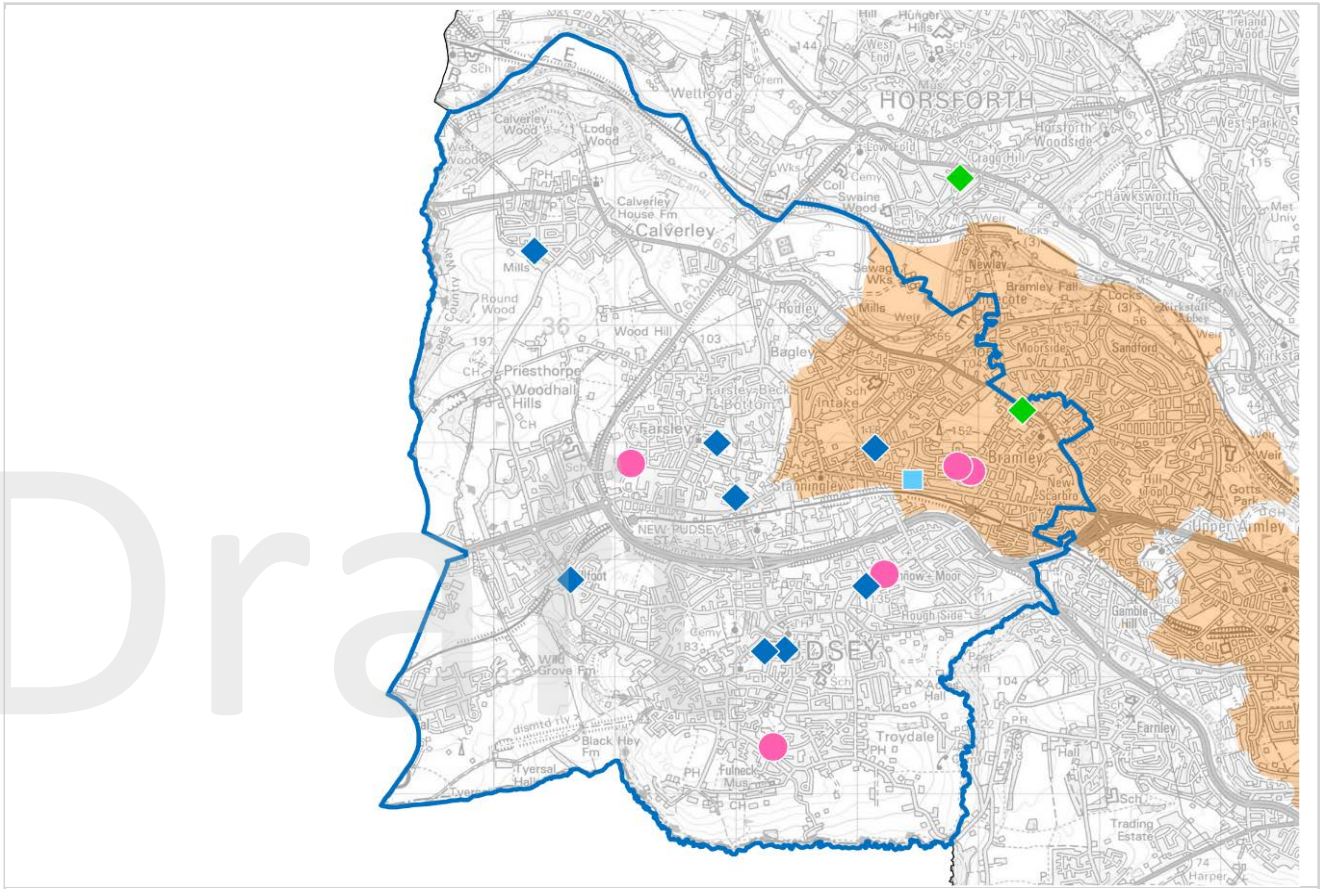
*GP data courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.*

# Area overview profile for Pudsey Integrated Neighbourhood Team

November 2017

This profile presents a high level summary using practice membership data. In a small number of cases practices and branches are members of different INTs, to account for this their patient data is allocated to the INT their nearest branch belongs to. Where data is not available at practice level it is aggregated to INT footprint on a purely geographical basis.

Space kept free for bullet point key messages from stakeholder engagement




Practices with more than one branch in this INT are listed once here and appear multiple times in the map: Hillfoot Surgery. Robin Lane Health And Wellbeing Centre. Pudsey Health Centre. Dr Lee & Partners. Sunfield Medical Centre. The Gables Surgery.

Note: A small number of practices have branches that are far enough apart to fall into different INTs. These practices are not listed here or shown in the map. The original INT boundaries do not relate to statistical geographies and so this footprint which is a nearest match LSOA area is used when aggregating geographical data.

INT footprint boundary

Most deprived 5 Children's Clusters

GP practice - member of INT

Children's centre within INT footprint

Community Health Development venue

Voluntary Community Sector venue

# Area overview profile for Pudsey Integrated Neighbourhood Team

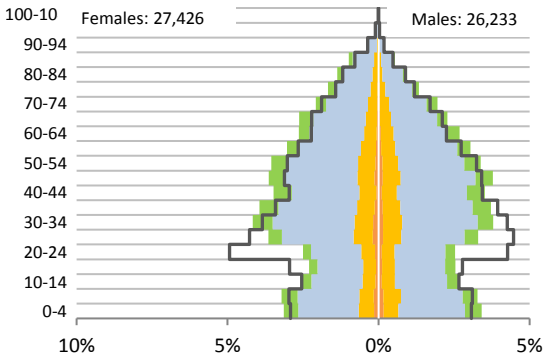
This profile presents a high level summary of data for the Pudsey Integrated Neighbourhood Team (INT), using practice membership data. In a small number of cases, practices and branches are members of different INTs, to account for this, their patient data is allocated to the INT their nearest branch belongs to. Where data is not available at practice level it is aggregated to INT footprint on a purely geographical basis ⚡.

All INTs are ranked to display variation across Leeds and this one is outlined in blue. Practices belonging to this INT are shown as individual blue dots. Actual counts are shown in blue text. Leeds overall is shown as dark grey, the most deprived fifth of Leeds** is shown in orange.

Where possible, INTs are colour coded red or green if rates are significantly worse or better than Leeds.

## Population: 53,659 in April 2017 *GP data*

Comparison of INT and Leeds age structures. Leeds is outlined in black, INT populations are shown as dark and light orange if resident inside the 1st or 2nd most deprived fifth of Leeds, and green if in the least deprived.

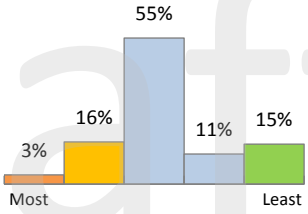



| GP recorded ethnicity, top 5 | % INT | % Leeds |
|---|---|---|
| White British | 73% | 62% |
| Not Recorded | 7% | 6% |
| Unknown | 6% | 1% |
| Other White Background | 3% | 9% |
| Not Stated | 3% | 2% |

*(April 2017)*

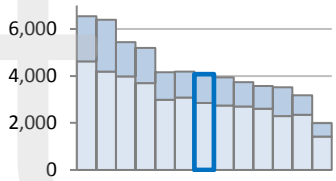
## Deprivation distribution

Proportions of INT within each deprivation fifth of Leeds April 2017. Leeds has equal proportions. **




## Aged 74+ *(April 2017)*

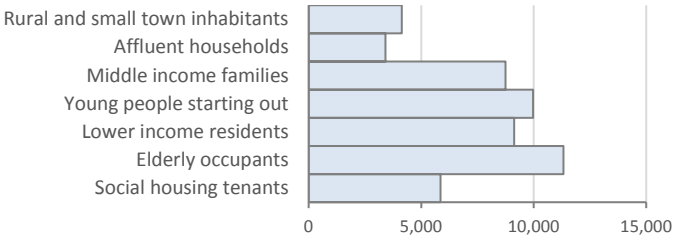
INTs ranked by number of patients aged over 74. 74y-84y in dark green, 85y and older in light green.




## Mosaic Groups in this INT population *(October 2017)*

The INT population as it falls into Mosaic population segment groups. These are counts of INT registered patients who have been allocated a Mosaic type using location data in October 2017.

http://www.segmentationportal.com



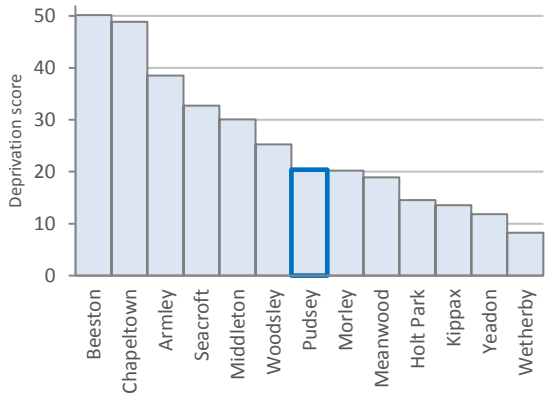

## Population counts in ten year age bands for each INT *(April 2017)*

| | Woodsley | Chapeltown | Meanwood | Middleton | Seacroft | Armley | Yeadon | Pudsey | Beeston | Morley | Holt Park | Kippax | Wetherby |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 80+ | 2,266 | 2,103 | 4,224 | 3,185 | 3,976 | 2,521 | 3,119 | 2,465 | 1,198 | 1,804 | 2,455 | 2,392 | 2,220 |
| 70-79 | 3,066 | 3,249 | 5,265 | 5,341 | 5,933 | 3,907 | 5,111 | 3,778 | 1,830 | 3,438 | 3,431 | 4,320 | 3,754 |
| 60-69 | 5,028 | 5,569 | 8,194 | 7,550 | 8,094 | 6,016 | 7,053 | 5,489 | 3,023 | 4,713 | 4,591 | 4,986 | 4,128 |
| 50-59 | 6,802 | 9,376 | 10,627 | 10,747 | 10,471 | 8,843 | 8,182 | 6,979 | 4,799 | 6,151 | 5,431 | 5,728 | 4,469 |
| 40-49 | 8,717 | 13,132 | 12,437 | 11,412 | 10,251 | 9,257 | 8,319 | 7,734 | 6,123 | 6,499 | 5,692 | 5,656 | 4,141 |
| 30-39 | 17,473 | 20,275 | 14,961 | 12,099 | 10,462 | 11,065 | 7,156 | 8,386 | 8,130 | 6,610 | 6,307 | 4,886 | 3,099 |
| 20-29 | 53,913 | 20,411 | 10,616 | 10,372 | 10,107 | 10,101 | 5,665 | 6,427 | 6,945 | 5,286 | 5,116 | 4,474 | 2,448 |
| 10-19 | 13,339 | 11,955 | 8,778 | 9,119 | 9,000 | 7,281 | 6,128 | 5,406 | 5,244 | 4,418 | 4,408 | 4,274 | 3,050 |
| 00-09 | 7,297 | 15,190 | 11,384 | 11,179 | 9,970 | 9,021 | 6,358 | 6,995 | 6,800 | 5,130 | 5,313 | 4,322 | 3,067 |
| Total | 117,901 | 101,260 | 86,486 | 81,004 | 78,264 | 68,012 | 57,091 | 53,659 | 44,092 | 44,049 | 42,744 | 41,038 | 30,376 |

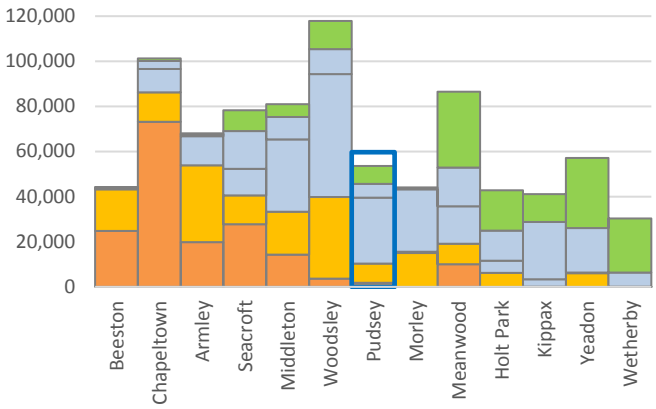
## Deprivation and the population of Pudsey INT *IMD2015 and GP data*

The INT deprivation score is calculated using the count and locations of patients registered with member practices in April 2017, and the Index of Multiple Deprivation 2015 (IMD). The larger the deprivation score, the more prominent the deprivation within the INT population. This INT deprivation score is 20.4, ranked number 7 in Leeds.

### INTs ranked by deprivation *score*




### INT population *sizes* ranked by deprivation score

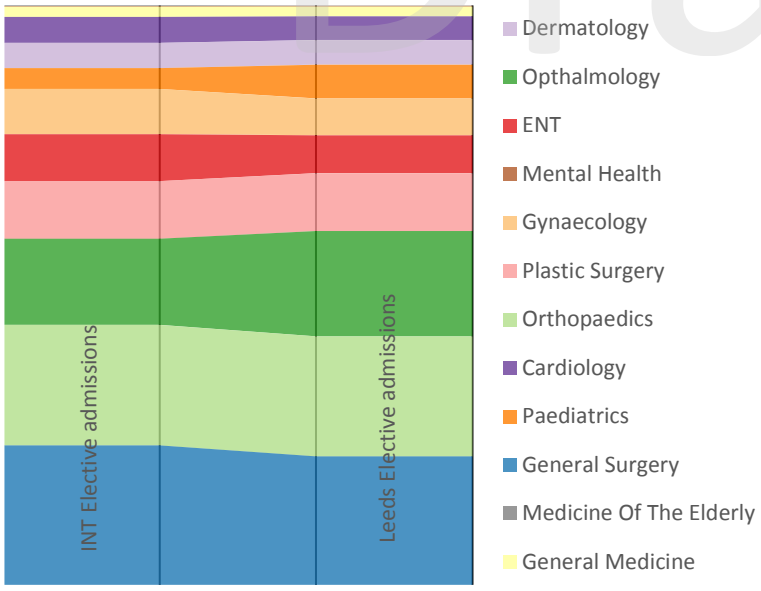



## Hospital admissions for this INT by specialty (2016/17)

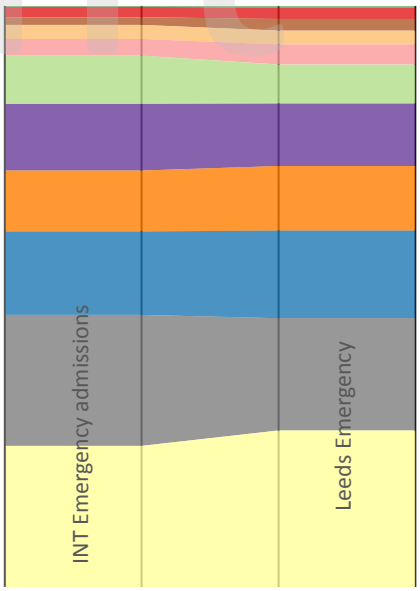
Elective (non-emergency) and emergency admission proportions for this INT are compared to Leeds below. Admissions data is divided between twelve hospital specialties and the additional group of 'others' which is where an admission does not have a recognised specialty assigned to it.

Non-emergency and emergency admission patterns obviously differ significantly, but of interest here is how the INT might differ to Leeds overall. The two charts us the same colour coding and both rank specialties by their contribution to Leeds overall, (the 'others' group is not charted or included in top 5 lists)

### Proportions of Elective admissions. INT vs Leeds




### Proportions of Emergency admissions. INT vs Leeds

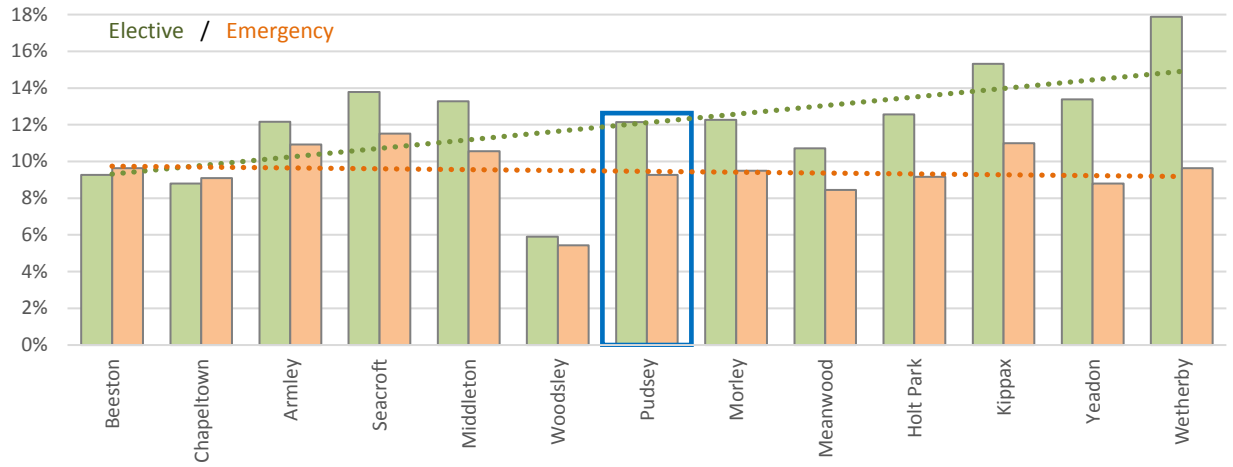



| INT Elective admissions top 5 | *% of INT admissions* | *Leeds proportion* |
|---|---|---|
| 1st General Surgery | *13%* | 12% |
| 2nd Orthopaedics | *11%* | 11% |
| 3rd Opthalmology | *8%* | 10% |
| 4th Plastic Surgery | *5%* | 5% |
| 5th ENT | *4%* | 4% |

| INT Emergency admissions top 5 | *% of INT admissions* | *Leeds proportion* |
|---|---|---|
| 1st General Medicine | *15%* | *16%* |
| 2nd Medicine Of The Elderly | *14%* | *12%* |
| 3rd General Surgery | *9%* | *9%* |
| 4th Cardiology | *7%* | *7%* |
| 5th Paediatrics | *6%* | *7%* |

## Elective and emergency admission *rates* and deprivation

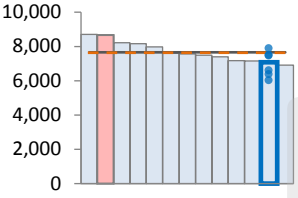
Hospital admission rates as percentage of whole INT populations. The INTs are *ordered by deprivation score* and there is a clear increase in proportion of elective admissions (green) as INTs become less deprived. Emergency admissions show a slightly inverted relationship with deprivation at INT level.




*Numerator: Count of all admissions. Denominator: Oct 2016 Leeds resident and registered population*

# Healthy children

## Asthma in children October 2016 (DSR per 100,000) *GP data*

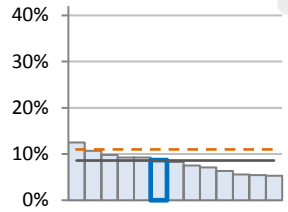



**Asthma - under 16s**

| | |
|---|---|
| INT | 7,070 |
| Leeds registered | 7,659 |
| Deprived fifth** | 7,633 |
| *INT count* | *582* |

*GP recorded* asthma in the under 16s, age standardised rates (DSR) per 100,000. Only the Seacroft INT asthma rate is significantly different to the Leeds rate.

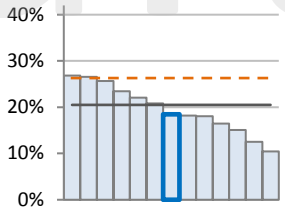
## Child obesity 2015-16 *NCMP, aggregated from LSOA to INT boundary*




**Obesity in Reception year**

| | |
|---|---|
| INT | 8.7% |
| Leeds registered | 8.6% |
| Deprived fifth** | 11.0% |

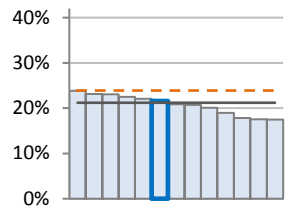
75 of 862 children in INT




**Obesity in Year 6**

| | |
|---|---|
| INT | 18.5% |
| Leeds registered | 20.5% |
| Deprived fifth** | 26.3% |

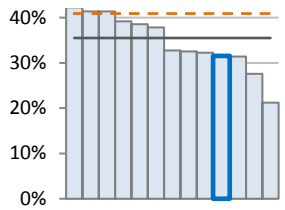
*123 of 665 children in INT*




**Obese *or* overweight, Reception year**

| | |
|---|---|
| INT | 21.6% |
| Leeds registered | 21.2% |
| Deprived fifth** | 23.9% |

*186 of 862 children*



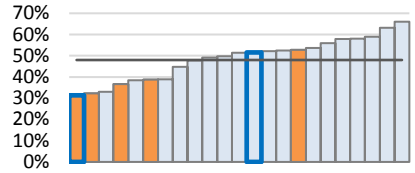

**Obese *or* overweight, Year 6**

| | |
|---|---|
| INT | 31.6% |
| Leeds registered | 35.5% |
| Deprived fifth** | 40.9% |

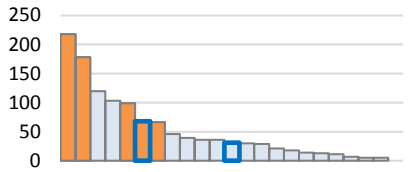
*210 of 665 children*

## Children's cluster data *Children and Young People's Plan Key Indicator Dashboard July 2017*

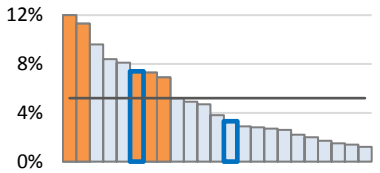
All 23 **Children's clusters** in Leeds, ranked below. Each INT footprint may be *overlapped* by one or more clusters and those having significant overlap with this INT are outlined in blue below. The five most deprived clusters in the city are shown in orange.




% with good achievement at the end of primary school (schools)

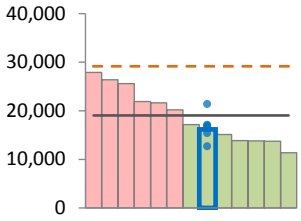



Looked after children



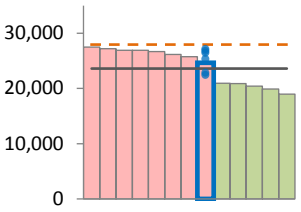

NEET - 'Not in education, employment or training'

## Healthy adults *GP data*




**Smoking (16y+)**

| | |
|---|---|
| INT | 16,200 |
| Leeds registered | 19,045 |
| Deprived fifth** | 29,163 |
| *INT count* | *7,210* |




**Obesity (BMI>30)**

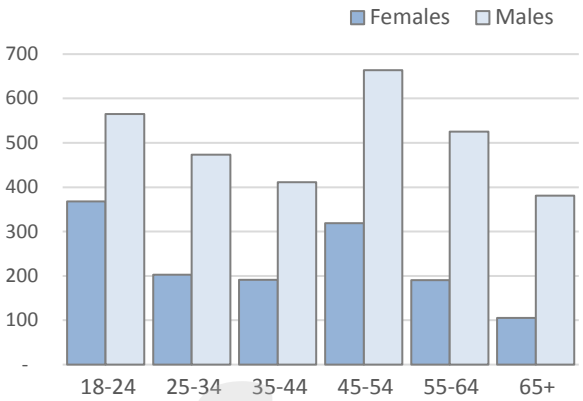
| | |
|---|---|
| INT | 24,653 |
| Leeds registered | 23,606 |
| Deprived fifth** | 27,951 |
| *INT count* | *9,701* |

(Within the population who have a recorded BMI)

## Audit-C alcohol dependency *GP data. Quarterly data collection, April 2017*

The Audit-C test assesses a patients drinking habits, assigning them a score. Patients scoring 8 or higher are considered to be at 'increasing risk' due to their alcohol consumption. In Leeds, almost half of the adult population have an Audit-C score recorded by a GP. Rates for age bands and females in Leeds are applied here to the INT registered population to form a picture of the alcohol risk in the whole INT adult population.

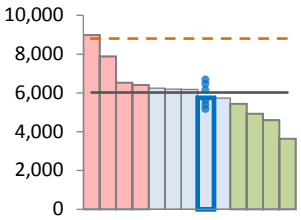
The table and chart below show the **predicted numbers of adults in this INT** registered population who would score 8 or higher.




| | 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|
| Females | 368 | 203 | 191 | 319 | 191 | 106 |
| Males | 565 | 473 | 411 | 664 | 525 | 381 |
| Persons | 892 | 677 | 613 | 991 | 719 | 511 |

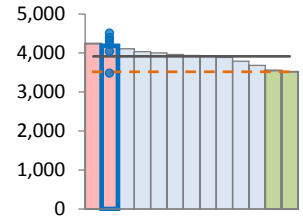
## Long term conditions, adults and older people *GP data*

GP data. Quarterly data collection, April 2017 (DSR per 100,000)



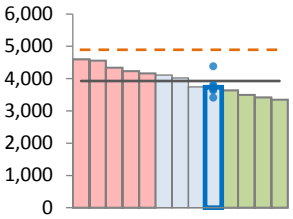

**Diabetes**

| | |
|---|---|
| INT | 5,754 |
| Leeds registered | 6,021 |
| Deprived fifth** | 8,802 |
| *INT count* | *2,774* |



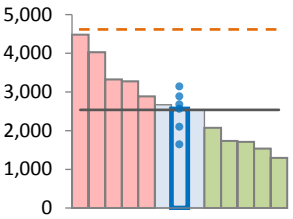

**Cancer** (January 2017)

| | |
|---|---|
| INT | 4,187 |
| Leeds registered | 3,915 |
| Deprived fifth** | 3,519 |
| *INT count* | *1,990* |




**CHD** (January 2017)

| | |
|---|---|
| INT | 3,736 |
| Leeds registered | 3,926 |
| Deprived fifth** | 4,894 |
| *INT count* | *1,747* |

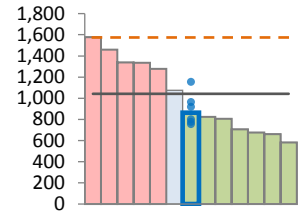



**COPD**

| | |
|---|---|
| INT | 2,563 |
| Leeds registered | 2,537 |
| Deprived fifth** | 4,617 |
| *INT count* | *1,200* |

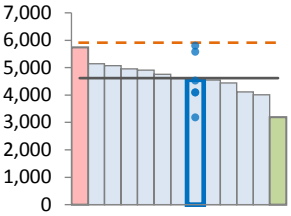
## Long term conditions, adults and older people continued *GP data*

GP data. Quarterly data collection, (DSR per 100,000)



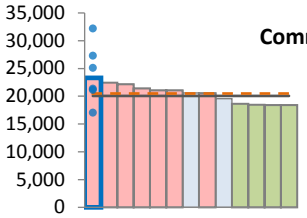

**Severe mental heath** (Jan '17)

| | |
|---|---|
| INT | 865 |
| Leeds registered | 1,042 |
| Deprived fifth** | 1,574 |
| *INT count* | *437* |




**Dementia (65+)** Jan '17

| | |
|---|---|
| INT | 4,555 |
| Leeds registered | 4,618 |
| Deprived fifth** | 5,911 |
| *INT count* | *415* |




**Common mental health** (Jan '17)

| | |
|---|---|
| INT | 23,296 |
| Leeds registered | 20,060 |
| Deprived fifth** | 20,496 |
| *INT count* | *12,146* |

The GP data charts show all 13 INTs in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. Where the INT is significantly above or below Leeds is it shaded red or green, if there is no significant difference then it is shown in blue. Blue circle indicators show rates for practices which are a member of the INT, in some instances scales are set which mean practices with extreme values are not seen.

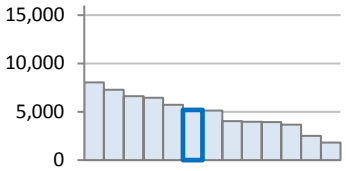
***Most deprived fifth, or quintile of Leeds - divides Leeds into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas. GP data only reflects those patients who visit their doctor, certain groups are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture.*



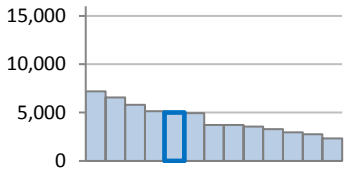
## Life limiting illness ⊁ *Census 2011, aggregated from MSOA to INT boundary*

INTs ranked by *number* of people reporting life limiting illness

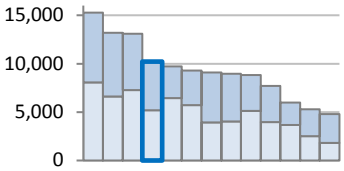
Life limiting illness, under 65



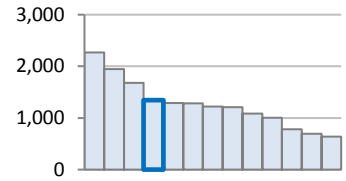

Life limiting illness, over 65



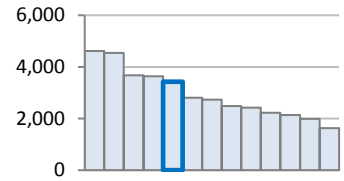

Life limiting illness all ages.
Under 65 years old in dark green. 65y and older in light green




## Carers providing 50+ hours care/week ⊁




## One person households aged 65+ ⊁




The number of people within the INT *area* in these categories are shown in the table below, the INT ranking position in Leeds is also shown.

⊁ This data is not related to INT practice membership so cannot be related back to practice membership of the INT. However each INT has a crude boundary allowing geographical data such as this to be allocated on that basis instead.

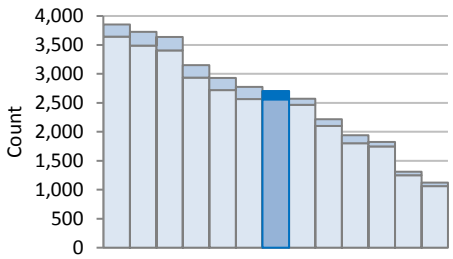
| | number | rank |
|---|---|---|
| Limiting Long Term Illness - All Ages | *10,199* | 4 |
| Limiting Long Term Illness - under 65 | *5,202* | 6 |
| Limiting Long Term Illness - 65+ | *4,997* | 5 |
| Providing 50+ hours care/week | *1,347* | 4 |
| One person households aged 65+ | *3,424* | 5 |

## People living with frailty and 'end of life'

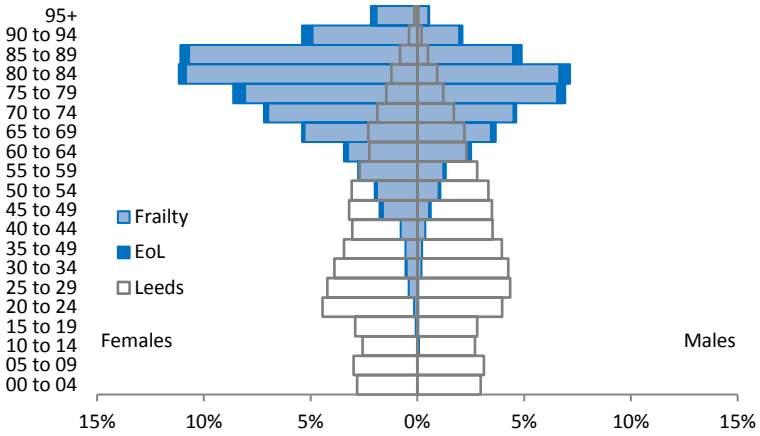
*Leeds data model September 2016 cohort*

Leeds Integrated Neighbourhood Teams ranked by combined count of End of Life and Frailty populations.

Total: 2,702. Frailty 2,562. End of life 140




INT (in blue) compared to Leeds by gender and age band.

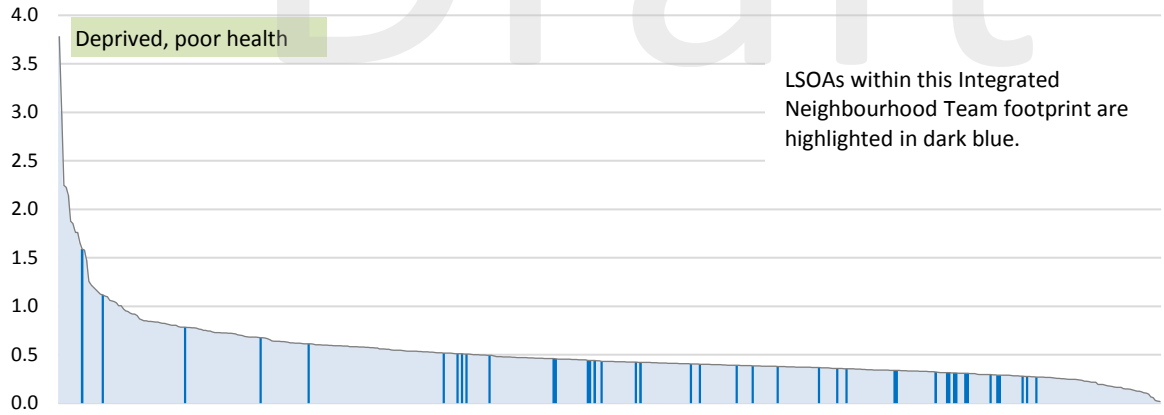


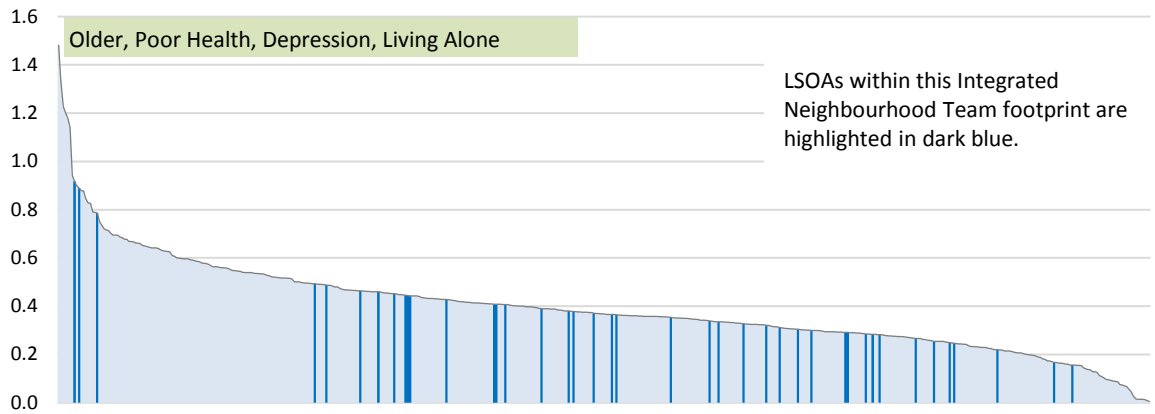

## Social Isolation Index ⚡

*LSOAs in INT footprint*

The Social Isolation Index visualises some of the broader determinants of health and social isolation as experienced by the older population. It brings together a range of indicators pulled from clinical, census and police sources. A shortlist was then used to generate population indexes, for two demographic groups across Leeds; 'Deprived, Poor Health' and 'Older, Poor Health, Depression, Living Alone'.

Each demographic group has a separate combination of indicators in order to better target the group characteristics, and variations in population sizes are removed during the index creation. The index levels show the likelihood a small area has of containing the demographic group in question. The higher the index score, the greater the probability that "at risk" demographics will be present, an area ranking 1st in Leeds is the most isolated in terms of that index. These charts show all Lower Super Output Areas (LSOAs) in Leeds, ranked by the indexes.



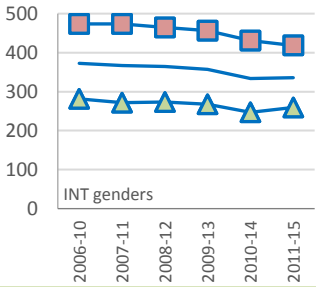

To find out more about the construction of the index, please contact James.Lodge@leeds.gov.uk

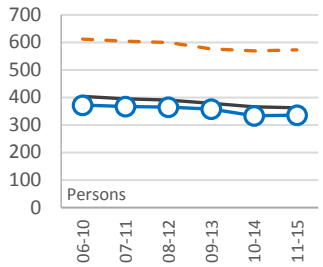
## Mortality, under 75s, age standardised rates per 100,000

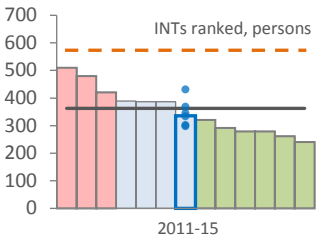
*ONS and GP registered populations*

| *"How different are the sexes in this INT"* | *"How different is this INT to Leeds"* | *"Where is this INT in relation to the others, and Leeds"* |
|---|---|---|
| Males | INT | INTs are ranked by the most recent rates and coloured as red or green if their rate is significantly above or below that of Leeds. Practice rates for those within this INT are shown as blue dots. This INT is highlighted with a blue border. |
| Females | Leeds | |
| Persons | Deprived fifth of Leeds** | |
| Shaded if significantly above Persons | Shaded if significantly above Leeds | |
| Shaded if significantly below Persons | Shaded if significantly below Leeds | |

### All cause mortality

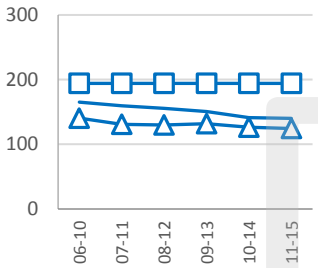


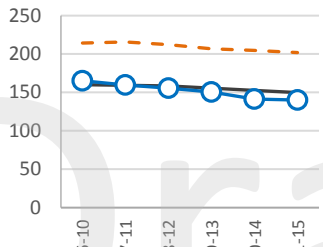



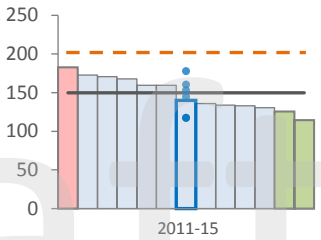




| Persons (DSR per 100,000) | |
|---|---|
| INT | 336 |
| Leeds resident | 363 |
| Deprived fifth** | 573 |
| *INT count* | *671* |

### Cancer mortality

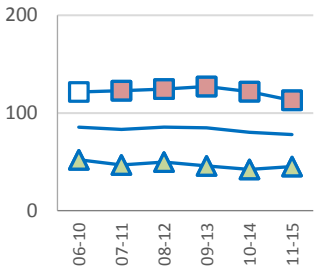


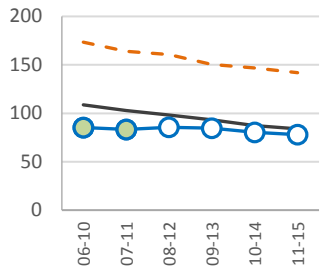



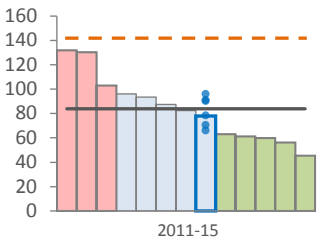




| Persons (DSR per 100,000) | |
|---|---|
| INT | 140 |
| Leeds resident | 150 |
| Deprived fifth** | 202 |
| *INT count* | *279* |

### Circulatory disease mortality

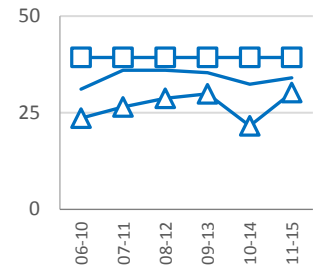


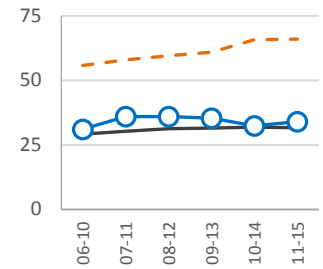



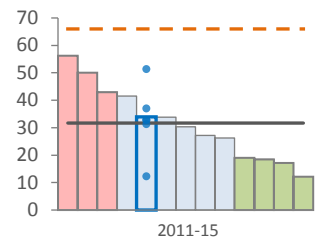




| Persons (DSR per 100,000) | |
|---|---|
| INT | 78 |
| Leeds resident | 84 |
| Deprived fifth** | 142 |
| *INT count* | *155* |

### Respiratory disease mortality



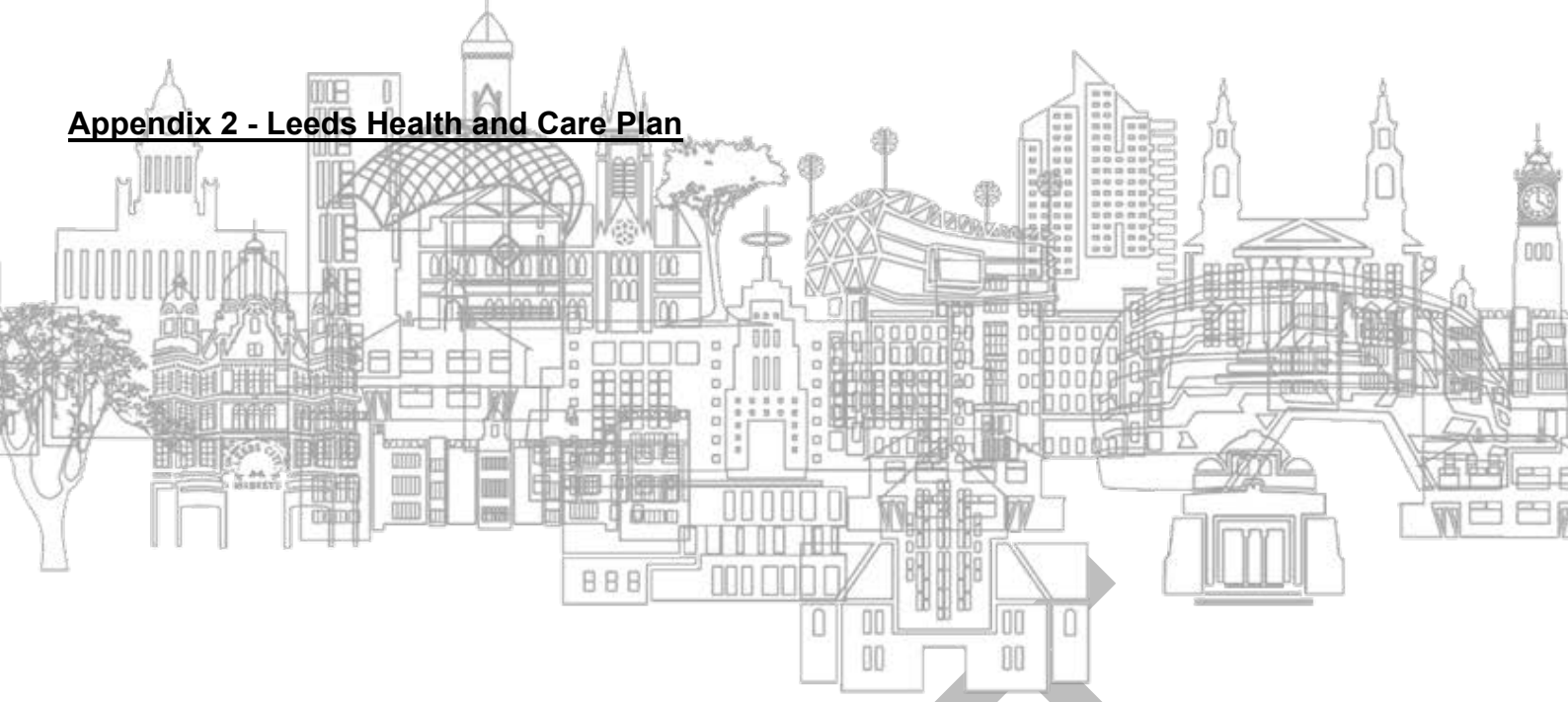




| Persons (DSR per 100,000) | |
|---|---|
| INT | 34 |
| Leeds resident | 32 |
| Deprived fifth** | 66 |
| *INT count* | *63* |

*GP data courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.*

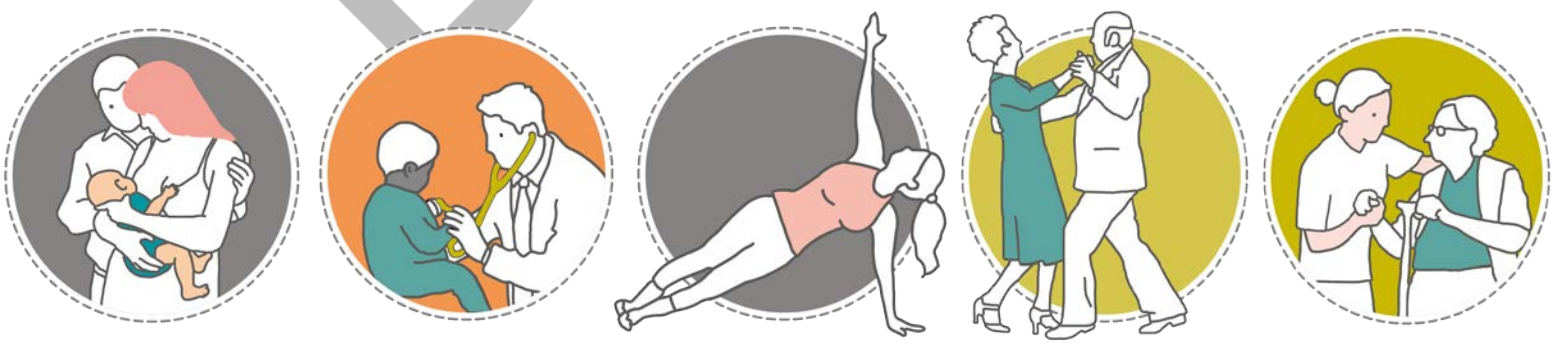
**Appendix 2 - Leeds Health and Care Plan**



# Leeds

## The best city for health and wellbeing





# Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:

'Leeds will be the best city for health and wellbeing'.

And a clear vision:

**'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.**

## 5 Outcomes

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities


## Indicators

- Infant mortality
- Good educational attainment at 16
- People earning a Living Wage
- Incidents of domestic violence
- Incidents of hate crime
- People affording to heat their home
- Young people in employment, education or training
- Adults in employment
- Physically active adults
- Children above a healthy weight
- Avoidable years of life lost
- Adults who smoke
- People supported to manage their health condition
- Children's positive view of their wellbeing
- Early death for people with a serious mental illness
- Employment of people with a mental illness
- Unnecessary time patients spend in hospital
- Time older people spend in care homes
- Preventable hospital admissions
- Repeat emergency visits to hospital
- Carers supported

Draft version 2.2 | Date 03/07/17

# *Leeds Health and Care Plan*

*By 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest*

***A plan that will improve health and wellbeing for all ages and for all of Leeds which will...***

| Protect the vulnerable and reduce inequalities | Improve quality and reduce inconsistency | Build a sustainable system within the reduced resources available |
|---|---|---|

***Our community health and care service providers, GPs, local authority, hospitals and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that...***

Have citizens at the centre of all decisions and change the conversation around health and care

Build on the strengths in ourselves, our families and our community; working **with** people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong

Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens

Use neighbourhoods as a starting point to further integrate our social care, hospital and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis

Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do

Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire

| **What this means for me...** | **"Living a healthy life to keep myself well"** | **"Health and care services working with me in my community"** | **"Hospital care only when I need it"** | **"I get rapid help when needed to allow me to return to managing my own health in a planned way"** |
|---|---|---|---|---|
| **Key actions that will be undertaken...** | 1. We will promote awareness and develop services to ensure the Best Start (conception to age 2) for every baby, with early identification and targeted support early in the life of the child.<br>2. We will promote the benefits of physical activity and improve the environments that encourage physical activity to become part of everyday life.<br>3. We will maximise every opportunity to reduce the harm from tobacco and alcohol, including enhancing the contribution by health and care staff.<br>4. We will have new accessible, integrated services that support people to live healthier lifestyles and promote emotional health and wellbeing for all ages, with a specific focus on those at high risk of developing respiratory, cardio-vascular conditions.<br>5. We will have a new, locally-based community service, 'Better Together', that can better build everyday resilience and skills in our most vulnerable populations. | 1. People living with severe breathing difficulties will know how to manage anxiety issues due to their illness and have a supportive plan about what's important to them by December 2017.<br>2. People living with severe frailty will be supported to live independently at home whenever possible, instead of having to go in and out of hospital.<br>3. People at high risk of developing diabetes and those living with diabetes will have access to support programmes to give them the confidence and skills to manage their condition by December 2017.<br>4. We will take the best examples where health and care services are working together outside of hospital and make them available across Leeds, for example muscle and joint services. | 1. Patients will stay the right time in hospital.<br>2. Patients with a mental health need will have their needs met in Leeds more often rather than being sent elsewhere to receive help.<br>3. We will meet more of patients' needs locally by ensuring their GPs can easily get advice from the right hospital specialist.<br>4. We will ensure that patients get the right tests for their conditions.<br>5. We will reduce the visits patients need to take to hospital before and after treatment.<br>6. We will ensure that patients get the best value medicines. | 1. We will review the ways that people currently access urgent health and social care services including the range of single points of access. The aim will be to make the system less confusing allowing a more timely and consistent response and when necessary appropriate referral into other services.<br>2. We will look at where and how people's needs are assessed and how emergency care planning is delivered (including end of life) with the aim to join up services, focus on the needs of people and where possible maintain their independence.<br>3. We will make sure that when people require urgent care, their journey through urgent care services is smooth and that services can respond to increases in demand as seen in winter.<br>4. We will change the way we organise services by connecting all urgent health and care services together to meet the mental, physical and social needs of people to help ensure people are using the right services at the right time. |

***Together these actions will deliver a new vision for community services and primary care in every neighbourhood. These will be supported by...***

Working as if we are one organisation, growing our own workforce from our diverse communities, supported by leading and innovative workforce education, training and technology

Having the best connected city using digital technology to improve health and wellbeing in innovative ways

Using existing buildings more effectively, ensuring that they are right for the job

Using our collective buying power to get the best value for our 'Leeds £'

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

# Contents





## Chapter 1

# Introduction

**Leeds is a city that is growing and changing.** As the city and its citizens change, so will the need of those who live here.

Leeds is an attractive place to live, over the next 25 years the number of people is predicted to grow by over 15 per cent. We also live longer in Leeds than ever before. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030. This is an incredible achievement but also means the city is going to need to provide more complex care for more people.

*"When the NHS was set up in 1948, half of us died before the age of 65.*

*Now, two thirds of the patients hospitals are looking after are over the age of 65……life expectancy is going up by five hours a day"*

**Simon Stevens, Chief Executive NHS England**

At the same time as the shift in the age of the population, more and more people (young and old) are developing long-term conditions such as #etes and other conditions related to lifestyle factors such as smoking, eating an unhealthy diet or being physically inactive.

Last year members of the Leeds Health and Wellbeing Board (leaders from health, care, the voluntary and community sector along and elected representatives of citizens in the city) set out the wide range of things we need to do to improve health and wellbeing in our city. This was presented in the **Leeds Health and Wellbeing Strategy 2016-2021.**

The Leeds Health and Wellbeing strategy is required by government to set out how we will achieve the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. It is a requirement from government that local health and care services take account of our Strategy in their spending and plans for services.

Leaders from the city's health and care services, and members of the Health and Wellbeing Board now want to begin a conversation with citizens, businesses and communities about the improvement people want to see in the health and wellbeing of Leeds citizens, and ask if individuals and communities should take greater responsibility for our health and wellbeing and the health and wellbeing of those around us.

Improving the health of the city needs to happen alongside delivering more efficient, services to ensure financial sustainability and offer better value for tax payers.

The NHS in England has also said what it thinks needs to change for our health services when it presented the "Five Year Forward View for the NHS". As well as talking about the role of citizens in improving the health and wellbeing of Leeds, the city's Health and Wellbeing Board must also work with citizens to plan what health and care services need to do to meet these changes:

- Health and Wellbeing Board members believe that too often care is organised around single illnesses rather than all of an individual's needs and strengths and that this should change.
- Leaders from health and care also believe many people are treated in hospitals when being cared for in their own homes and communities would give better results.

- Services can sometimes be hard to access and difficult to navigate. Leeds will make health and care services more person-centred, joined-up and focussed on prevention.

Improving the health of the city needs to happen alongside delivering better value for tax payers and more efficient services. This is a major challenge.

What is clear is that nationally and locally the cost of our health and care system is rising faster than the money we pay for health and care services. Rising costs are partly because of extra demand (such as greater numbers of older people with health needs) and partly because of the high costs of delivering modern treatments and medicines.

If the city carries on without making changes to the way it manages health and care services, it would be facing a financial gap. Adding up the difference each year between the money available and the money needed, by 2021 the total shortfall would be around £700 million across Leeds.

As residents, health care professionals, elected leaders, patients and carers, we all want to see the already high standards of care that we have achieved in our city further improved to meet the current and future needs of the population.

## What is this document for?

We are publishing a Draft Leeds Health and Care Plan at a very early stage whilst ideas are developing. Ideas so far have been brought together from conversations with patients, citizens, doctors, health leaders, voluntary groups, local politicians, research and what has worked well in other areas. This gives everyone a start in thinking what changes may be helpful.

The Draft Leeds Health and Care Plan sets out initial ideas about how we could protect the vulnerable and reduce inequalities, improve care quality and reduce inconsistency and build a sustainable system with the reduced resources available. The key ideas are included at the front of this document; we want to help explain how we could make these changes happen.

This report contains a lot more information about the work of health and care professionals, your role as a citizen and the reasons for changing and improving the health and wellbeing of our city. Once you have taken a look we want to hear from you.

By starting a conversation together as people who live and work in Leeds we can begin creating the future of health and care services we want to see in the city.

We want you to consider the challenges and the plans for improving the health and wellbeing of everyone in Leeds. We want you to tell us what you think, so that together, we can make the changes that are needed to make Leeds the best city for health and wellbeing ensuring people are at the centre of all decisions.

Chapters 10 & 11 are where we set out what happens next, and includes information about how you can stay informed and involved with planning for a healthier Leeds.

## Chapter 2

# Working *with* you: the role of citizens and communities in Leeds

### Working *with* people

We believe our approach must be to work 'with' people rather than doing things 'for' or 'to' them. This is based on the belief that this will get better results for all of us and be more productive.

This makes a lot of sense. We know that most of staying healthy is the things we do every day for ourselves or with others in our family of community. Even people with complex health needs might only see a health or care worker (such as a doctor, nurse or care worker) for a small percentage of the time, it's important that all of us, as individuals, have a good understanding of how to stay healthy when the doctor isn't around.

*Work health and care leaders have done together in Leeds has helped us to understand where we could be better.*

*What we need to do now is work with the people of Leeds to jointly figure out how best to make the changes needed to improve, and the roles we will all have in improving the health of the city.*

This is a common sense or natural approach that many of us take already but can we do more? We all need to understand how we can take the best care of ourselves and each other during times when we're at home, near to our friends, neighbours and loved ones.

***The NHS Constitution***

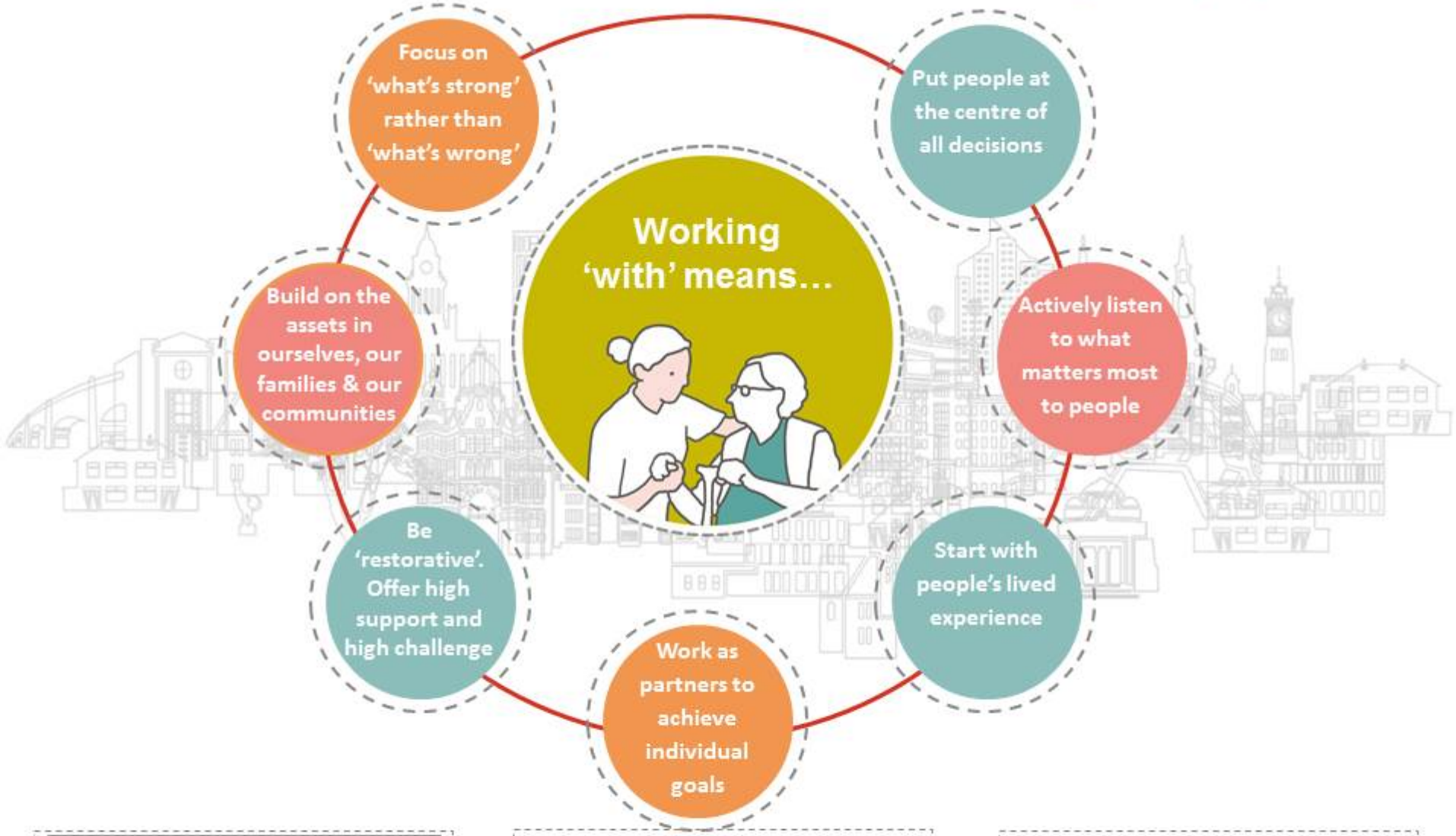
***Patients and the public: our responsibilities***

*The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.*

*Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.*

Figure 1 on the next page, gives an indication of the new way in which health and care services will have better conversations with people and work with people.

# Better conversations: A whole city approach to working with people




In Leeds we believe wellbeing starts with people: The connections, conversations and relationships between services and citizens and between people in their families and communities have a huge impact on us all.

Quality conversations make a difference, especially when used positively by services to work 'with' people to find solutions rather than things being done 'to' people or 'for' them.

Our commitment to working with people is about bringing these beliefs to life, by developing the skills and mind-set across Leeds' health and care workforce to use solutions that work *with* people wherever it is safe, appropriate and the right thing to do.

## Joining things up

We all know good health for all of us is affected by the houses we live in, the air we breathe, the transport we use and the food that we eat. We know good health starts at birth and if we set good patterns early they continue for a life time. We know that physical and mental health are often closely linked and we need to treat them as one.

We need to recognise the connections between our environment and our health. This will mean ensuring that the physical environment, our employment and the community support around us are set up in a way that makes staying healthy the easiest thing to do.

It will mean working with teams in the city who are responsible for work targeted at children and families, planning and providing housing and the built environment, transport and others. It will also involve us working with charities, faith groups, volunteer organisations and businesses to look at what we can all do differently to make Leeds a healthier place in terms of physical, mental and social wellbeing.

## Taking responsibility for our health

If we're going to achieve our ambition to be a healthier happier city, then each of us as citizens will have a role to play too.

In some cases this might mean taking simple steps to stay healthy, such as taking regular exercise, stopping smoking, reducing the amount of alcohol we drink and eating healthier food.

As well as doing more to prevent ill health, we will all be asked to do more to manage our own health better and, where it is safe and sensible to do so, for us all to provide more care for ourselves. These changes would mean that people working in health and care services would take more time to listen, to discuss things and to plan with you so that you know what steps you and your family might need to take to ensure that you are able to remain as healthy and happy as possible, even if living with an on-going condition or illness.

***Cycling*** *just 30 miles a week could* ***reduce your risk*** *of* ***cancer*** ***by 45%***

*That's the same as* ***riding to work*** *from* ***Headingley*** *to the* ***Railway Station*** *each day.*

This wouldn't be something that would happen overnight, and would mean that all of us would need to be given the information, skills, advice and support to be able to better manage our own health when the doctor, nurse or care worker isn't around.
By better managing our own health, it will help us all to live more independent and fulfilled lives, safe in the understanding that world class, advanced health and care services are there for us when required.

This won't be simple, and it doesn't mean that health and care professionals won't be there when we need them. Instead it's about empowering us all as people living in Leeds to live lives that are longer, healthier, more independent and happier.

Working together, as professionals and citizens we will develop an approach to health and wellbeing that is centred on individuals and helping people to live healthy and independent lives.

## Chapter 3

# This is us: Leeds, a compassionate city with a strong economy

We are a city that is thriving economically and socially. We have the fastest growing city economy outside London with fast growing digital and technology industries.

**Leeds City Council has been recognised as Council of the Year** as part of an annual awards ceremony in which it competed with councils from across the country.

The NHS is a big part of our city, not only the hospitals we use but because lots of national bodies within the NHS have their home in Leeds, such as NHS England. **We have one of Europe's largest teaching hospitals (Leeds Teaching Hospitals NHS Trust) which in 2016 was rated as good in a quality inspection**. The NHS in the city provides strong services in the community and for those needing mental health services.

Leeds has a great history of successes in supporting communities and neighbourhoods to be more self-supporting of older adults and children, leading to better wellbeing for older citizens and children, whilst using resources wisely to ensure that help will always be there for those of us who cannot be supported by our community.

The city is developing **innovative general practice** (GP / family doctor) services that are among the best in the country. These innovative approaches include new partnerships and ways of organising community and hospital skills to be delivered in partnership with your local GPs and closer to your home. This is happening at the same time as patients are being given access to extended opening hours with areas of the city having GPs open 7 days per week.

Leeds is also the first major UK city where every GP, healthcare and social worker can electronically access the information they need about patients through a joined-up health and social care record for every patient registered with a Leeds GP.

We have **three leading universities in Leeds**, enabling us to work with academics to gain their expertise, help and support to improve the health of people in the city.

Leeds is the third largest city in the UK and **home to several of the world's leading health technology and information companies** who are carrying out research, development and manufacturing right here in the city. For example, we are working with companies like Samsung to test new 'assistive technologies' that will support citizens to stay active and to live independently and safely in their own homes.

The city is a hub for investment and innovation in using health data so we can better improve our health in a cost effective way. We are encouraging even more of this type of work in Leeds through a city-centre based "Innovation District".

Leeds has worked hard to achieve a **thriving 'third sector'**, made up of charities, community, faith and volunteer groups offering support, advice, services and guidance to a diverse range of people and communities from all walks of life.

***The Reginald Centre in Chapeltown*** *is a good example of how health, care and other council services are able to work jointly, in one place for the benefit of improving community health and wellbeing.*

*The centre hosts exercise classes, a jobshop, access to education, various medical and dental services, a café, a bike library, and many standard council services such as housing and benefits advice.*

## Chapter 4

# The Draft Leeds Health and Care Plan: what will change and how will it affect me?

### Areas for change and improvement

To help the health and care leaders in Leeds to work better together on finding solutions to the city's challenges, they have identified four main priority areas of health and care on which to focus.

**Prevention ("Living a healthy life to keep myself well")** – helping people to stay well and avoid illness and poor health.
Some illnesses can't be prevented but many can. We want to reduce avoidable illnesses caused by unhealthy lifestyles as far as possible by supporting citizens in Leeds to live healthier lives.

By continuing to promote the benefits of healthy lifestyles and reducing the harm done by tobacco and alcohol, we will keep people healthier and reduce the health inequalities that exist between different parts of the city.

Our support will go much further than just offering advice to people. We will focus on improving things in the areas of greatest need, often our most deprived communities, by providing practical support to people. The offer of support and services available will increase, and will include new services such as support to everyday skills in communities where people find it difficult to be physically active, eat well or manage their finances for example.

We will make links between healthcare professionals, people and services to make sure that everyone has access to healthy living support such as opportunities for support with taking part in physical activity.

**Self-management ("Health and care services working with me in my community")** – providing help and support to people who are ill, or those who have on-going conditions, to do as much as they have the skills and knowledge to look after themselves and manage their condition to remain healthy and independent while living normal lives at home with their loved ones.

People will be given more information, time and support from their GP (or family doctor) so

that they can plan their approach to caring for themselves and managing their condition, with particular support available to those who have on-going health conditions, and people living with frailty.

**Making the best use of hospital care and facilities ("Hospital care only when I need it")** – access to hospital treatment when we need it is an important and limited resource, with limited numbers of skilled staff and beds.

More care will be provided out of hospital, with greater support available in communities where there is particular need, such as additional clinics or other types of support for managing things like muscle or joint problems that don't really need to be looked at in hospital. Similarly there will be more testing, screening and post-surgery follow-up services made available locally to people, rather than them having to unnecessarily visit hospital for basic services as is often the case now.

Working together, we will ensure that people staying in hospital will be there only for as long as they need to be to receive help that only a hospital can provide.

Reducing the length of time people stay in hospital will mean that people can return to their homes and loved ones as soon as it is safe to do so, or that they are moved to other places of care sooner if that is what they need, rather than being stuck in hospitals unnecessarily.

Staff, beds, medicines and equipment will be used more efficiently to improve the quality of care that people receive and ensure that nothing is wasted.

**Urgent and Emergency Care ("I get rapid help when needed to allow me to return to managing my own health in a planned way")** – making sure that people with an urgent health or care need are supported and seen by the right team of professionals, in the right place for them first time. It will be much easier for people to know what to do when they need help straight away.
Currently there are lots of options for people and it can be confusing for patients. As a result, not all patients are seen by the right medical professional in the right place.

For example, if a young child fell off their scooter and had a swollen wrist, what would you do? You could call your GP, dial 999 ring NHS111, drive to one of the two A&E units, visit the walk-in centre, drive to one of the two minor injuries units, visit your local pharmacy or even just care for them at home and see how they feel after having some rest, a bag of frozen peas and some Calpol.

Given the huge range of options and choices available, it's no wonder that people struggle to know what to do when they or their loved ones have an urgent care need.

We want to make this much simpler, and ensure that people know where to go and what to do so that they're always seen by the right people first time.

## GP and Primary Care Changes

The biggest and most important idea to help with the above is to really change services to being more joined up around you – more integrated and more community focused.

The most important place to do this is in our communities and neighbourhoods themselves. It starts with recognising how communities can keep us healthy – through connecting us with activity, work, joining in with others and things that help gives us a sense of wellbeing. GPs, (primary care) nurses and other community services such as voluntary groups working closer as one team could focus better on keeping people healthy and managing their own health. We could also use health information better to target those at risk of getting ill and intervening earlier.

This will mean our whole experience of our local health service (or other community services such as a social worker) could change over time. We may find that in future we see different people at the GP to help us – for instance a nurse instead of a Doctor and we would have to spend less time travelling or talking to different services to get help. We may get more joined up help for housing, benefits and community activities through one conversation. It is likely that to do this GPs need to join some of their practices together to share resources, staff and premises to make sure they can work in this new way. Other health, care and community services will need to join in with the approach. We will all still be on our own GP list and have our own named doctor though – that will not change.

This big change would mean we would need to ensure we train our existing and future workforces to work with you in new ways. The approach would also use new technologies to help you look after your own wellbeing and help professionals to be more joined up.

The approach will bring much of the expertise of hospital doctors right into community services which would mean less referral to specialists and ensuring we do as much as we can in your community. This should mean fewer visits to hospital for fewer procedures.

Getting all of this right will help people be healthier and happier. It will mean we will further reduce duplication in the way that we spend money on care. Figure 2 shows how our use of the money available for heath and care in Leeds might change. Note the shift towards more investment in Public Health where money will be used to encourage and support healthier lives for people in Leeds.

## Where money is spent on health and care in Leeds, now and in the future

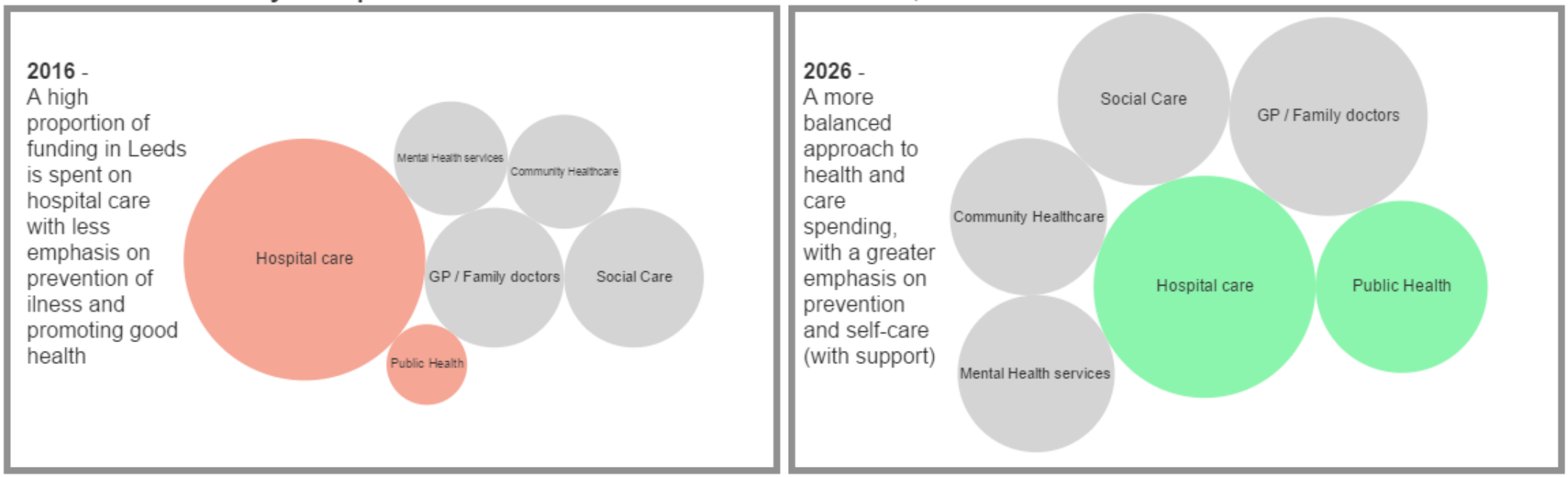



**Figure 2 – An indicative view of the way that spending on the health and care system in Leeds may change**

## Chapter 5

# So why do we want change in Leeds?

### Improving health and wellbeing

Most of us want the best health and care.

Most health and care services in Leeds are good. However, we want to make sure we are honest about where we can improve and like any other service or business, we have to look at how we can improve things with citizens.


Working together with the public, with professionals working in health and care and with the help of data about our health and our health and care organisations in the city, we have set out a list of things that could be done better and lead to better results for people living in Leeds.

This will mean improving the quality of services, and improving the way that existing health and care services work with each other, and the way that they work with individuals and communities.

We want to share our ideas with people in Leeds to find out whether citizens agree with the priorities in this plan. Citizens will be asked for their views and the information we receive will help us to improve the initial ideas we have and help us to focus on what is of greatest importance to the city and its people.

What we need to do now is work with people in the city to jointly figure out how best to make the changes and the roles we will all have in improving the health of the city.

### Three gaps between the Leeds we have, and the Leeds we want

**1. Reducing health inequalities (the difference between the health of one group of people compared with another)**

- Reducing the number of early deaths from cancer and heart disease, both of which are higher in Leeds than the average in England
- Closing the life expectancy gap that exists between people in some parts of Leeds and the national average
- Reducing the numbers of people taking their own lives. The number of suicides is increasing in the city.

**2. Improving the quality of health and care services in Leeds**

- Improving the quality of mental health care, including how quickly people are able to access psychological therapy when they need it
- Improving the reported figures for patient satisfaction with health and care services
- Making access to urgent care services easier and quicker

- Reducing the number of people needing to go into hospital
- Reducing the number of people waiting in hospital after they've been told they're medically fit to leave hospital
- Ensuring that enough health and care staff can be recruited in Leeds, and that staff continue working in Leeds for longer (therefore making sure that health and care services are delivered by more experienced staff who understand the needs of the population)
- Improving people's access to services outside normal office hours.

### 3. Ensuring health and care services are affordable in the long-term

If we want the best value health services for the city then we need to question how our money can best be spent in the health and care system. Hospital care is expensive for each person treated compared to spending on health improvement and prevention. We need to make sure that we get the balance right to ensure we improve people's health in a much more cost effective way.

We believe the health and wellbeing of citizens in Leeds will be improved through more efficient services investing more thought, time, money and effort into preventing illness and helping people to manage on-going conditions themselves. This will help prevent more serious illnesses like those that result in expensive hospital treatment.

We think we can also save money by doing things differently. We will make better use of our buildings by sharing sites between health and care and releasing or redeveloping underused buildings. A good example of this is the Reginald Centre in Chapeltown.

Better joint working will need better, secure technology to ensure people get their health and care needs met. This might be through better advice or management of conditions remotely to ensure the time of health and care professionals is used effectively. For example having video consultations may allow a GP to consult with many elderly care home patients and their carers in a single afternoon rather than spending lots of time travelling to and from different parts of the city.

We plan to deliver better value services for tax payers in Leeds by making improvements to the way that we do things, preventing more illness, providing more early support, reducing the need for expensive hospital care and increasing efficiency.

*Preventable* ***Diabetes***
*costs taxpayers in Leeds*
***£11,700*** *every* ***hour***

Changing the way that we work to think more about the improvement of health, rather than just the treatment of illness, will also mean we support the city's economic growth - making the best use of every 'Leeds £'.

This will be important in the coming years, as failure to deliver services in a more cost effective way would mean that the difference between the money available and the money spent on health and care services in Leeds would be around £700 million.

This means if Leeds **does the right things now we will have a healthier city, better services and ensure we have sustainable services.** If we ignored the problem then longer term consequences could threaten:

- **A shortage of money and staff shortages**
- **Not enough hospital beds**
- **Longer waiting times to see specialists**
- **Longer waiting times for surgery**
- **Higher levels of cancelled surgeries**
- **Longer waiting times for GP appointments**
- **Longer waiting times in A&E**
- **Poorer outcomes for patients**

None of us wants these things to happen to services in Leeds which is why we're working now to plan and deliver the changes needed to improve the health of people in the city and ensure that we have the health and care services we need for the future.

This is why we are asking citizens of Leeds, along with people who work in health and care services and voluntary or community organisations in the city to help us redesign the way we can all plan to become a healthier city, with high quality support and services.

## Chapter 6

# How do health and care services work for you in Leeds now?

Our health and care service in Leeds are delivered by lots of different people and different organisations working together as a partnership. This partnership includes not only services controlled directly by the government, such as the NHS, but also services which are controlled by the city council, commercial and voluntary sector services.

### The government, the Department of Health and the NHS

The department responsible for NHS spending is the Department of Health. Between the Department of Health and the Prime Minister there is a Secretary of State for Health. GPs were chosen by Government to manage NHS budgets because they're the people that see patients on a day-to-day basis and arguably have the greatest all-round understanding of what those patients need as many of the day to day decisions on NHS spending are made by GPs.

### Who decides on health services in Leeds? The role of 'Commissioners'

About £72 billion of the NHS £120 billion budget is going to organisations called Clinical Commissioning Groups, or CCGs. They're made up of GPs, but there are also representatives from nursing, the public and hospital doctors.

The role of the CCGs in Leeds is to improve the health of the 800,000 people who live in the city. Part of the way they do it is by choosing and buying – or commissioning - services for people in Leeds.

They are responsible for making spending decisions for a budget of £1.2bn.

CCGs can commission services from hospitals, community health services, and the private and voluntary sectors. Leeds has a thriving third sector (voluntary, faith and community groups) and commissioners have been able to undertake huge amounts of work with communities by working with and commissioning services with the third sector.

As well as local Leeds commissioning organisations, the NHS has a nationwide body, NHS England, which commissions 'specialist services'. This helps ensure there is the right care for health conditions which affect a small number of people such as certain cancers, major injuries or inherited diseases.

### Caring for patients – where is the health and care money spent on your behalf in Leeds?

Most of the money spent by the local NHS commissioners in Leeds, and by NHS England as part of their specialist commissioning for people in Leeds is used to buy services provided by four main organisations or types of 'providers', these include:

## GPs (or family doctor) in Leeds

GPs are organised into groups of independent organisations working across Leeds. Most people are registered with a GP and they are the route through which most of us access help from the NHS.

## Mental Health Services in Leeds

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides mental health and learning disability services to people in Leeds, including care for people living in the community and mental health hospital care.

*Mental Health affects many people over their lifetime. It is estimated that 20% of all days of work lost are through mental health, and 1 in 6 adults is estimated to have a common mental health condition.*

## Hospital in Leeds

Our hospitals are managed by an organisation called Leeds Teaching Hospitals NHS Trust which runs Leeds General Infirmary (the LGI), St James's Hospital and several smaller sites such as the hospitals in Wharfedale, Seacroft and Chapel Allerton.

## Providing health services in the community for residents in Leeds

There are lots of people in Leeds who need some support to keep them healthy, but who don't need to be seen by a GP or in one of the city's large, hospitals such as the LGI or St James. For people in this situation Leeds Community Healthcare NHS Trust provides many community services to support them.

Services include the health visitor service for babies and young children, community nurse visits to some housebound patients who need dressings changed and many others.

## Who else is involved in keeping Leeds healthy and caring for citizens?

As well as the money spent by local NHS commissioners, Leeds City Council also spends money on trying to prevent ill health, as well as providing care to people who aren't necessarily ill, but who need support to help them with day to day living.

## Public health – keeping people well and preventing ill health

Public health, or how we keep the public healthy, is the responsibility of Leeds City Council working together with the NHS, Third Sector and other organisations with support and guidance from Public Health England.

Public Health and its partners ensure there are services that promote healthy eating, weight loss, immunisation, cancer screening and smoking cessation campaigns from Public Health England and national government.

## Social care - supporting people who need help and support

Social care means help and support - both personal and practical - which can help people to lead fulfilled and independent lives as far as possible. Social care covers a wide range of services, and can include anything from help getting out of bed and washing, through to providing or commissioning residential care homes, day service and other services that support and maintain people's safety and dignity.

It also includes ensuring people's rights to independence and ensuring that choice and control over their own lives is maintained, protecting (or safeguarding) adults in the community and those in care services.

Adult social care also has responsibility for ensuring the provision of good quality care to meet the long-term and short-term needs of people in the community, the provision of telecare, providing technology to support independent living, occupational therapy and equipment services.

Lots of questions have been asked about whether the government has given enough money for social care, and how it should be paid for.

During 2016/17 Leeds City Council paid for long term packages of support to around 11,000 people.

Approximately 4,230 assessments of new people were undertaken during the 2016/17 with around 81.5% or 3,446 of these being found to be eligible to receive help.

Leeds City Council commissions permanent care home placements to around 3,000 people at any time, and around 8,000 people are supported by Leeds Adult Social Care to continue living in their communities with on-going help from carers.

Figure 3, shows how the local decision makers (NHS Commissioners and Leeds City council) spend health and care funding on behalf of citizens in Leeds.

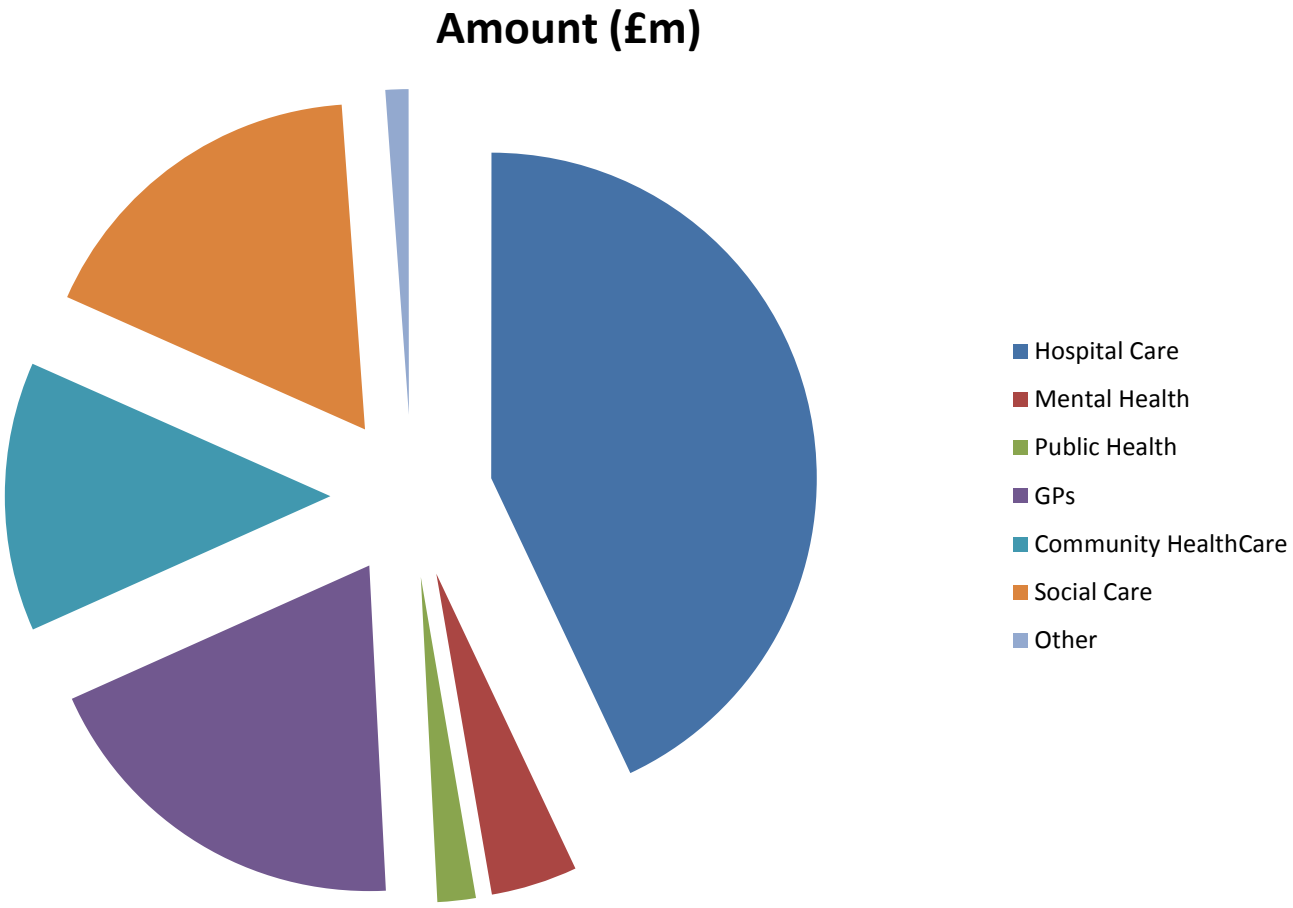



**Figure 3 – Indicative spending of health and care funding in Leeds**



## Children and Families Trust Board

The Children and Families Trust Board brings together senior representatives from the key partner organisations across Leeds who play a part in improving outcomes for children and young people.

They have a shared commitment to the Leeds Children & Young People's Plan; the vision for Leeds to be the best city in the UK for children and young people to grow up in, and to be a Child Friendly city that invests in children and young people to help build a compassionate city with a strong economy.

In Leeds, the child and family is at the centre of everything we do. All work with children and young people starts with a simple question: what is it like to be a child or young person growing up in Leeds, and how can we make it better?

The best start in life provides important foundations for good health. Leeds understands the importance of focussing on the earliest period in a child's life, from pre-conception to age two, in order to maximise the potential of every child.

The best start in life for all children is a shared priority jointly owned by the Leeds Health and Wellbeing Board and the Children & Families Trust Board through the Leeds Best Start Plan; a broad collection of preventative work which aims to ensure a good start for every baby.

Under the Best Start work in Leeds, babies and parents benefit from early identification and targeted support for vulnerable families early in the life of the child. In the longer term, this

will promote social and emotional capacity of the baby and cognitive growth (or the development of the child's brain).

By supporting vulnerable families early in a child's life, the aim is to break the cycles of neglect, abuse and violence that can pass from one generation to another.

The plan has five high-level outcomes:

- Healthy mothers and healthy babies
- Parents experiencing stress will be identified early and supported
- Well prepared parents
- Good attachment and bonding between parent and child
- Development of early language and communication

Achieving these outcomes requires action by partners in the NHS, Leeds City Council and the third sector. A partnership group has been established to progress this important work.

## Leeds Health and Wellbeing Board

The Health and Wellbeing Board helps to achieve the ambition of Leeds being a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest.

The Board membership comprises Elected Members and Directors at Leeds City Council, Chief Executives of our local NHS organisations, the clinical chairs of our Clinical Commissioning Groups, the Chief Executive of a third sector organisation, Healthwatch Leeds and a representative of the national NHS. It exists to improve the health and wellbeing of people in Leeds and to join up health and care services. The Board meets about 8 times every year, with a mixture of public meetings and private workshops.

The Board gets an understanding of the health and wellbeing needs and assets in Leeds by working on a Joint Strategic Needs Assessment (JSNA), which gathers lots of information together about people and communities in the city.

The Board has also developed a Health and Wellbeing Strategy which is about how to put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. This strategy is the blueprint for how Leeds will achieve that. It is led by the partners on the Leeds Health and Wellbeing Board and it belongs to everyone in the city.

## Healthwatch Leeds

People and patients are at the heart of our improvement in health. This means their views are at the heart of how staff and organisations work and that they are at the heart of our strategy.

Healthwatch Leeds is an organisation that's there to help us get this right by supporting people's voices and views to be heard and acted on by those who plan and deliver services in Leeds.

## Chapter 7

# Working with partners across West Yorkshire

Leeds will make the most difference to improving our health by working together as a city, for the benefit of people in Leeds.

There are some services that are specialist, and where the best way to reduce inequalities, improve the quality of services and ensure their financial sustainability is to work across a larger area. In this way we are able to plan jointly for a larger population and make sure that the right services are available for when people need them but without any duplication or waste.

NHS organisations and the council in Leeds are working with their colleagues from the other councils and NHS organisations from across West Yorkshire to jointly plan for those things that can best be done by collaborating across West Yorkshire.

This joint working is captured in the **West Yorkshire and Harrogate Health and Care Partnership**.

*The West Yorkshire and Harrogate Health and Care Partnership is built from six local area plans: Bradford District & Craven; Calderdale; Harrogate & Rural District; Kirklees; Leeds and Wakefield. This is based around the established relationships of the six Health and Wellbeing Boards and builds on their local health and wellbeing strategies. These six local plans are where the majority of the work happens.*

*We have then supplemented the plan with work done that can only take place at a West Yorkshire and Harrogate level. This keeps us focused on an important principle of our health and care partnership - that we deal with issues as locally as possible*

The West Yorkshire and Harrogate Health and Care Partnership has identified nine priorities for which it will work across West Yorkshire to develop ideas and plan for change, these are:

- Prevention
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised services
- Hospitals working together
- Standardisation of commissioning policies

## Chapter 8

# Making the change happen

The work to make some changes has already started. However, we don't yet have all of the answers and solutions for exactly how we will deliver the large changes that will improve the health and wellbeing of people in Leeds.

This will require lots of joint working with professionals from health and care, and importantly lots of joint working with you, the public as the people who will be pivotal to the way we do things in future.

We will work with partners from across West Yorkshire to jointly change things as part of the West Yorkshire and Harrogate Health and Care Partnership (where it makes sense to work together across that larger area). Figure 4 (below) shows the priorities for both plans.


**Figure 4: Draft Leeds Health and Care Plan & West Yorkshire & Harrogate Health and care Partnership priorities**

## Chapter 9

# How the future could look…

We haven't got all the answers yet, but we do know what we would like the experiences and outcomes of people in Leeds to look like in the future.

We have worked with patient groups and young people to tell the stories of 8 Leeds citizens, and find out how life is for them in Leeds in 2026, and what their experience is of living in the best city in the country for health and wellbeing.

***NOTE - This work is on-going. Upon completion, we will have graphic illustrations in videos produced for each of the cohorts:**

1. Healthy children
2. Children with long term conditions (LTC)
3. Healthy adults –occasional single episodes of planned and unplanned care
4. Adults at risk of developing a LTC
5. Adults with a single LTC
6. Adults with multiple LTCs
7. Frail adults - Lots of intervention
8. End of Life – Support advice and services in place to help individuals and their families through death
9. We will also be developing health and care staff stories

## Chapter 10

# What happens next?

The Leeds Health and Care Plan is really a place to pull together lots of pieces of work that are being done by lots of health and care organisations in Leeds.

Pulling the work together, all into one place is important to help health care professionals, citizens, politicians and other interested stakeholders understand the 'bigger picture' in terms of the work being done to improve the health of people in the city.

### Change is happening already

Much of this work is already happening as public services such as the NHS and the Council are always changing and trying to improve the way things are done.

Because much of the work is on-going, there isn't a start or an end date to the Leeds plan in the way that you might expect from other types of plan. Work will continue as partners come together to try and improve the health of people in the city, focussing on some of the priority areas we looked at in **Chapter 4**.

### Involving you in the plans for change

We all know that plans are better when they are developed with people and communities; our commitment is to do that so that we can embed the changes and make them a reality.

We will continue to actively engage with you around any change proposals, listening to what you say to develop our proposals further.

We are starting to develop our plans around how we will involve, engage and consult with all stakeholders, including you, and how it will work across the future planning process and the role of the Health and Wellbeing Boards.

### Working with Healthwatch

Planning our involvement work will include further work with Healthwatch and our voluntary sector partners such as Leeds Involving People, Voluntary Action Leeds, Volition and many others to make sure we connect with all groups and communities.

### When will changes happen?

While work to improve things in Leeds is already happening, it is important that improvements happen more quickly to improve the health of residents and the quality and efficiency of services for us all.

### Joint working

Working together, partners of the Health and Wellbeing Board in Leeds will continue to engage with citizens in Leeds to help decide on the priorities for the city, and areas that we should focus on in order to improve the health of people living in Leeds.

Alongside the Health and Wellbeing Board, the heads of the various health and care organisations in the city will work much more closely through regular, joint meetings of the Partnership Executive Group (a meeting of the leaders of each organisation) to ensure that there is a place for the more detailed planning and delivery of improvements to health and care in the city.

## Who will make decisions?

Ultimately, there will be lots of changes made to the way that health and care services work in Leeds. Some of these will be minor changes behind the scenes to try and improve efficiency.

Other changes will be more significant such as new buildings or big changes to the way that people access certain services.

The planning of changes will be done in a much more joined up way through greater joint working between all partners involved with health and care services in the city (including citizens). Significant decisions will be discussed and planned through the Health and Wellbeing Board. Decision making however will remain in the formal bodies that have legal responsibilities for services in each of the individual health and care organisations.

## Legal duties to involve people in changes

Leeds City Council and all of the NHS organisations in Leeds have separate, but similar, obligations to consult or otherwise involve the public in our plans for change.

For example, CCGs are bound by rules set out in law, (section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012).

This is all fairly technical, but there is a helpful document that sets out the advice from NHS England about how local NHS organisations and Councils should go about engaging local people in plans for change.

The advice can be viewed here:

https://www.england.nhs.uk/wp-content/uploads/2016/09/engag-local-people-stps.pdf

NHS organisations in Leeds must also consult the local authority on 'substantial developments or variation in health services'. This is a clear legal duty that is set out in S244 of the NHS Act 2006.

## Scrutiny

Any significant changes to services will involve detailed discussions with patients and the public, and will be considered by the Scrutiny Board (Adult Social Services, Public Health and the NHS). This is a board made up of democratically elected councillors in Leeds, whose job it is to look at the planning and delivery of health and care services in the city, and consider whether this is being done in a way that ensures the interests and rights of patients are being met, and that health and care organisations are doing things according to the rules and in the interests of the public.

## Chapter 11

# Getting involved

Sign up for updates about the Draft Leeds Health and Care Plan

***NOTE –Final version will include details of how to be part of the Big Conversation**

### Other ways to get involved

You can get involved with the NHS and Leeds City Council in many ways locally.

1. **By becoming a member of any of the local NHS trusts in Leeds:**
    - Main Hospitals: Leeds Teaching Hospitals Trust - http://www.leedsth.nhs.uk/members/becoming-a-member/
    - Mental Health: Leeds & York Partnership Foundation Trust - http://www.leedsandyorkpft.nhs.uk/membership/foundationtrust/Becomeamember
    - Leeds Community Healthcare Trust – http://www.leedscommunityhealthcare.nhs.uk/working-together/active-and-involved/

2. **Working with the Commissioning groups in Leeds by joining our Patient Leader programme:**https://www.leedswestccg.nhs.uk/content/uploads/2015/11/Patient-leader-leaflet-MAIN.pdf

3. **Primary Care –Each GP practice in Leeds is required to have a Patient Participation Group**
   Contact your GP to find out details of yours. You can also attend your local Primary Care Commissioning Committee, a public meeting where decisions are made about the way that local NHS leaders plan services and make spending decisions about GP services in your area.

4. **Becoming a member of Healthwatch Leeds or Youthwatch Leeds:**
    - http://www.healthwatchleeds.co.uk/content/help-us-out
    - http://www.healthwatchleeds.co.uk/youthwatch