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

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

Focuses includes:

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

Recent successes under this programme include:

Project and Description	Successes
Better Together The programme focusses on the issues that lead to poor health, such as social isolation, and use a community development approach to work with individuals, groups and communities to help them improve their situation and live longer, healthier lives.	Outreach work has engaged over 18,000 people from the 10% most deprived communities into community groups and programmes to improve general health and wellbeing.
'One You Leeds' (OYL) OYL is designed to support Leeds residents to start and maintain a healthy lifestyle. It has a key aim to support the ethos of 'improving the health of the poorest the fastest'. There is a specific aim around increasing access by specific target populations (e.g. people living in deprived Leeds, people at risk of long term conditions, pregnant women and emerging migrant populations).	OYL continues to achieve high levels of referrals into the service.
Alcohol Programme This programme aims to continue to reduce harm from alcohol through: • promoting safe alcohol consumption as the norm • reducing access to alcohol by young people and providing; and • promoting alternative routes to behaviour change for those people who would prefer to self-help.	There has been a significant amount of activity over the last year aimed at alcohol awareness, including; Alcohol awareness week held from 19 to 25 November which saw significant alcohol related health promotion. The 'No Regrets' campaign, an online responsible drinking campaign aimed at 18-25 year olds. Forward Leeds holding a series of events across the city, where people were able to make positive pledges to change their drinking behaviour. There has also been a focus on secondary prevention for people who may be attending health services for a condition and present an opportunity to discuss smoking and alcohol use. For example, the Nursing Specialist Assessment 'e-form' is now live on all inpatient wards throughout Leeds Teaching Hospitals NHS Trust (LTHT). This means alcohol and tobacco screening is now being undertaken as part of every inpatient's admission into the hospital as they come onto the wards.

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

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

This programme vision is that in 5 years' time people will be able to confidently manage their own health and wellbeing and services will be delivered in a way that identifies and addresses need earlier. Self-Management and Proactive Care will be embedded into every relevant pathway across Leeds? We are achieving this by:

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

Recent successes under this programme include:

Project and Description	Success
Better conversations Better conversations is a culture change programme moving the conversation between worker and citizen from a paternalistic dynamic where the worker is viewed as the 'expert' and has a role to 'fix' the citizen, towards an equal partnership where the worker looks to enable the citizen	To date 48 skills days have been developed overall, with over 700 attendees from 52 different health and care organisations across the city including both the statutory and third sector. Specific skills sessions have taken place for Seacroft and Crossgates LCPs and a session will be taking place with Pudsey LCP in June with a view to potentially rolling sessions out across all LCPs to ensure that focused localities develop skills together at the same time. 89% of attendees agreed or strongly agreed that they will use the skills practiced in their role.
Diabetes Structured Education Programme To improve uptake for Type 2 Diabetes education courses with an emphasis on targeted groups (men over 40 and BME) with the overall outcome that people feel well supported and confident to manage their condition. Self-Management support is now part of the ICS Universal Personalised care plan programme as detailed by NHS England (NHSE).	In the last quarter of 2018 there have been 347 referrals into the Diabetes Structured Education Programme. Diabetes education sessions have increased from 33 to 125 per annum. The percentage of people reporting an improved confidence to manage their condition after the course is sustained at 100%. Representation in those attending of the targeted groups for the programme remain strong – men over 40 years (52%), proportion of attendees from deprived areas (62%) and people from BAME groups (51%).

National Diabetes Prevention Programme (NNDP) The programme aims to help people reduce their risk of developing Type 2 diabetes, by offering them a referral to an intensive lifestyle intervention programme. The intervention consists of improved diet, weight loss and increased physical activity. Self-Management support is now part of the ICS Universal Personalised care plan as detailed by NHSE	Between April 1 2018 and March 31 2019 5,542 people have been referred for the National Diabetes Prevention Programme (NNDP).
Breathe Easy The project aims to develop an integrated network of respiratory peer support groups in Leeds which will result in higher quality and more consistency in terms of how patients with COPD manage their condition.	The 10 Breathe Easy groups in Leeds are in a position of sustainability. The groups are located in Bramley, Middleton, Gipton, Hunslet, Yeadon, Beeston, Allerton Bywater, Harehills, Richmond Hill and Osmondthorpe. All groups are now operating from low/no cost venues and the numbers attending are growing. This project has led to a wider programme of developing peer support networks with people with long term conditions.
Collaborative Care Support Planning (CCSP) CCSP facilitates a change in people's annual review for long term conditions. It enables the person to be more prepared for the consultation by ensuring they receive their results and relevant information in advance of the review, and therefore be a true partner in their care. The results forms a collaborative discussion between professional and person, focusing on "what is important to the person" enabling person centered goals to be agreed to support people to self-manage their condition.	There have been 85,859 CCSP Annual reviews performed in Leeds between April 1st 2018 and March 31st 2019.This programme is part of the ICS Universal Personalised care plan programme as detailed by NHSE. Leeds has been recognised by the ICS and NHSE as meeting the quality markers for personalised care planning.
Social Prescribing Social Prescribing offers activity, social and cultural interventions in communities as an alternative to or adjunct to medical interventions.	Social Prescribing is also now part of the ICS Universal Personalised care plan programme as detailed by NHSE There has been 3749 referrals to the Social Prescribing service. The city is on track to meet the target of 5,000 referrals for the year. Following reprocurement by the CCG there will now be one provider (a consortia) covering the whole of the city, and ensuring that all LCPs have social prescribers.

Virtual Respiratory Ward Leeds Community Healthcare NHS Trust's virtual respiratory ward was expanded to cover Armley to help patients with long-standing respiratory conditions.	The virtual respiratory ward is designed to help those with Chronic Obstructive Respiratory Disease (COPD) exacerbations avoid being admitted to hospital and support earlier discharges for those that have been admitted. COPD can be caused by a number of things including smoking and genetics.
Frailty Unit A multi-disciplinary team work on the unit providing medical and holistic care for patients over the age of 80, or from 65 if they have particular frailty needs. Emergency departments can be really busy and noisy with lots going on. This can be really difficult for older patients while they are waiting, particularly if they are frail and may have dementia. The Frailty Unit is set away from the main emergency department, so it's a lot quieter and a much better environment for our older patients to be while they're being assessed.	The latest available figures (November 2018) show that the frailty unit at St James's Hospital has prevented 951 admissions in nine months, around 1902 bed days.

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

Progress is being made with activities with focus to:

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

Recent successes under this programme include:

Project and Description	Successes
Cancer Programme The objective of the programme is to achieve the best in cancer care for the people of Leeds. The programme is centred around four areas of focus: • Prevention awareness and screening • Early diagnosis • Living with and beyond cancer • High quality modern services	713 additional people have completed a bowel screening test since April 2018 after being contacted by practice champions. Furthermore, the Accelerate Coordinate Evaluate (ACE) pilot pathway is for patients with non-specific but concerning symptoms has now been mainstreamed and the 1000th patient has just recently been referred on this pathway. Early evaluation indicates ACE provides faster diagnosis and clarity to patients and physicians, improves diagnostic findings of other significant but non-cancer conditions and as equally or more cost effective than previous approaches.
Care Navigation Leeds and York NHS Partnership Foundation Trust (LYPFT) have appointed a nurse to a Care Navigator role based at The Mount. She attends operational delayed discharge forums at Leeds Teaching Hospital Trust (LTHT) as well as The Mount in order to co-ordinate arrangements for people with complex needs in dementia, regardless of hospital setting.	The role has become a valued member of the LTHT Operational Discharge Group, ensuring people are referred to the LYPFT Enhanced Care Homes Team. The role works in partnership with commissioners to invite interested providers to discuss individual needs, develop the care home market and support individuals to leave hospital.
Enhanced Care Home Team The initiative aims to reduce avoidable delays that older people with complex dementia needs face when being placed from hospital beds to suitable long-term care home placement. They do this through proactively pursuing care home placement options as well as then providing care homes with rapid access to intensive short term input/care.	Between July and December 2018, successfully placed 42 service users to care homes who otherwise would have been in hospital for longer. There are a number examples of supporting care homes in admission avoidance. This service has now received recurrent funding.
Medicines and Consumables The objective of this programme is for patients to receive the medicines that are the best value for them and for Leeds.	Significant progress has been made in making the best use of the Leeds pound whilst improving service in the following areas; • Stoma care • Oral nutritional supplements • Silk Garments • Wound Dressings

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

Progress is being made with activities to:

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

Recent successes under this programme include:

Project and Description	Successes
Urgent Treatment Centres (UTC) This programme will develop UTCs across the city. UTC's offer urgent primary care, both for minor injury and minor illness. The proposal is to develop five UTC's in Leeds. Three UTC's will be in the community (St Georges, Middleton, Wharfedale, Otley and potentially in Seacroft) and two will be co-located at the A&E departments (St James University Hospital and Leeds General Infirmary)	The St Georges Centre in Middleton, South Leeds was formally designated as an UTC in December 2018 by NHS England. This means it meets the national mandate as set out by NHS England. A formal 12 week public engagement programme which sought views on the proposals for UTC's in Leeds has recently been undertaken-analysis is underway during May 2019. The development of Urgent Treatment Centres are underway at the Wharfdale site and at St James's Hospital.
Clinical Assessment Service (CAS) This project aims to provide a Clinical Assessment Service for the Leeds population. People who ring NHS 111 will receive a clinical assessment over the telephone, reducing the number of people who need to receive a face to face appointment. The ambition is for all single points of access to link into the CAS, and for the CAS to book appointments into services when a face to face appointment is required. This will standardise and simplify access into health and care services.	The 6 month pilot has been evaluated. Findings show that 50% of all calls to the Leeds CAS were dealt with over the phone. The learning from the pilot is helping to inform how the service can expand for Phase 2. The scope for Phase 2 (2019/20) is currently being determined.

High Intensity Users Project The service provides tailored support to people who attend A&E frequently to address underlying social, medical and mental health issues.	Those that use the service for three or more months have been found to have better experiences and outcomes – being supported to access the services they most need rather than A&E. Emergency Department attendances and ambulance conveyances were reduced by 53% over the 12 months for the 72 people the service worked with in the last year.
Yorkshire Ambulance Service (YAS) YAS are now able to refer patients directly into the Leeds Frailty Unit at St James's hospital. This means that ambulance staff can assess patients they are called to attend to with a 'frailty score' and determine if they may be best supported in a specialist unit that supports people with similar conditions. This means patients may bypass a potentially delaying and stressful period in the hospital Emergency Department.	The project allows ambulances to take people straight to the most appropriate place for their care giving them the best chance of avoiding admission. In the first 15 days 18 people benefitted from this pathway.

Collective resource areas that enable transformation

Estates successes include:

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

Digital successes include:

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

Workforce successes include:

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