The Healthy Leeds Plan

2023 -2028

Plain text version

1. Introduction

Our vision is for Leeds to be a healthy and caring city for all ages where people who are the poorest improve their health the fastest, as set out in the Leeds Health and Wellbeing Strategy (https://www.leeds.gov.uk/docs/Council%20and%20democracy/LHWS%202016-21.pdf). The Healthy Leeds Plan sets out the health and care contribution towards achieving this vision. It describes the outcomes we want to achieve for the people of Leeds and our plans for doing so. It also outlines our five-year strategic vision, as well as setting out a detailed one-year operational plan to achieve local, regional, and national priorities. In delivering our plan, we will focus on equitable access, excellent experience, optimal outcomes and ensuring we get the best value from the Leeds pound (NHS Triple Aim: https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-integration-measures).

The principles of our Health and Care Partnership underpin how we work together to deliver on our ambition and vision as set out in the Leeds Health and Wellbeing Strategy:

- **We start with people**: working with people instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds' people, communities, paid and unpaid carers, and workforce.
- **We are Team Leeds**: working as if we are one organisation, being kind, taking collective responsibility for and following through on what we have agreed. Difficult issues are put on the table, with a high support, high challenge attitude.
- **We deliver:** prioritising actions over words. Using intelligence, every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds pound.

Starting with people means listening to their experiences of health and care services and acting on what matters to them. We will ensure that service changes and improvements across the city are undertaken with people at the centre and in line with what matters to them: better communication with people; effective co-ordination of health and care services; and compassion in the delivery of services. To ensure the Healthy Leeds Plan addresses local needs alongside regional and national priorities, this document also represents our contribution to the West Yorkshire Integrated Care Board (ICB) Joint Forward Plan (JFP), the West Yorkshire Integrated Care Strategy (https://www.wypartnership.co.uk/publications/west-yorkshire-integrated-care-strategy) and the NHS Long Term Plan (https://www.longtermplan.nhs.uk/).

2. Our city and vision

Leeds Health and Care Partnership

Leeds is a great, forward looking, northern city with strong innovation, creativity, and commitment from partners to work together to improve our population's health and wellbeing outcomes and to address health inequalities. It is a richly diverse city with people of different ages, backgrounds, cultures, and beliefs working alongside each other.

The Leeds Health and Care Partnership consists of organisations across Leeds including:

- Leeds and York Partnership NHS Foundation Trust
- Leeds Teaching Hospital NHS Trust
- Leeds Community Healthcare NHS Trust
- NHS West Yorkshire Integrated Care Board
- Leeds City Council
- Leeds GP Confederation
- Healthwatch Leeds
- Forum Central
- St Gemma's Hospice
- Sue Ryder Wheatfields Hospice

The Leeds Health and Care Partnership exists to improve the health and wellbeing of the 880,000 people in our city. It operates in a city with a unique combination of assets and ways of working, which gives us a firm foundation for continuous improvement and innovation. We strive to be inclusive in our partnership, starting with people and bringing together a network of statutory and non-statutory third sector, health, local government, academic and industry partners. We also have a role beyond the boundaries of the city, by delivering services regionally and as a key partner within the West Yorkshire Health and Care Partnership alongside the four other places in West Yorkshire (Bradford District and Craven, Calderdale, Kirklees, and Wakefield District). Following the principle of subsidiarity, we work together at West Yorkshire level where it makes sense to do so, where there is a challenge or concern and to share good practice.

The third sector is the collective term for the Voluntary, Community and Social Enterprise (VCSE) organisations and networks which add so much value to the lives of the people in Leeds, particularly in deprived areas and communities of interest (groups of people who have a shared identity or experiences). Leeds has a challenged but comparatively thriving third sector and inspiring community assets, which is a fundamental part of our integrated health and social care system. Forum Central (https://forumcentral.org.uk/) represents this diverse sector in Leeds, as part

of the Health and Care Partnership – connecting third sector organisations with decision makers across health and social care. This strong third sector voice helps influence our strategy, policy and ways of working across our Population and Care Delivery Boards (https://www.healthandcareleeds.org/have-your-say/shape-the-future/populations/), Local Care Partnerships (LCPs, https://www.healthandcareleeds.org/about/partners/local-care-partnerships/) and the executive meetings of the West Yorkshire ICB.

In addition to our thriving third sector, Leeds has many anchor organisations within the city. These anchor organisations are an important presence as either large employers, purchasers of goods and services locally or as owners of important buildings, parks, and similar assets in local communities. They include the national organisations that allow us to influence and engage national decision-making and policy for health and wellbeing. Also included are the three leading universities who, as part of the Leeds Academic Health Partnership (https://www.leedsacademichealthpartnership.org/), can help us solve some of the city's hardest health and care challenges and work with industry partners to accelerate the adoption of innovation.

Our health and care providers are equally important anchor organisations, and Leeds' anchor organisations (https://www.inclusivegrowthleeds.com/leeds-anchors) are committed to providing good-quality employment, training, skills, and careers for the diverse population of Leeds and the region, positively impacting some of the critical determinants of health and wellbeing.

Our city vision

The Leeds Health and Wellbeing Strategy has set the vision for the city:

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

We know that health and wellbeing is affected by social, economic, and environmental factors beyond good healthcare. These are often referred to as the wider determinants of health and include factors such as income, education, access to green spaces and healthy food, type of employment, and housing. Inequalities in the wider determinants of health can lead to heath inequalities between different populations, and therefore addressing these wider socio-economic inequalities is a crucial part of reducing health inequalities for the people of Leeds (The Kings Fund: https://www.kingsfund.org.uk/publications/what-are-health-inequalities#what).

As such, whilst the Healthy Leeds Plan represents the critical contribution health and care organisations can make towards realising the vision of the Health and

Wellbeing Strategy, it also sits alongside other important strategies that will help improve the lives and wellbeing of the people of Leeds.

Our 'Best City Ambition' describes the three core pillars of our city's future ambition - Health and Wellbeing, Inclusive Growth and Zero Carbon (https://www.leeds.gov.uk/plans-and-strategies/best-city-ambition).

The Leeds Inclusive Growth Strategy sets out how we can make Leeds a healthier, greener, and more inclusive economy that works for everyone (https://www.inclusivegrowthleeds.com/sites/default/files/2022-05/Leeds-Inclusive-Growth-Strategy-FINAL.pdf) .

The Net Zero Ambition sets out our commitment to be carbon neutral (https://www.leeds.gov.uk/plans-and-strategies/climate-change).

Leeds has also committed to become a Marmot City and is working in partnership with the Institute of Health Equity to take a strategic, whole-system approach to improving health equity.

Achieving our local vision and ambition will support work taking place across West Yorkshire and will contribute to delivering the region's 10 Big Ambitions (https://www.wypartnership.co.uk/application/files/3615/7918/6822/WYSTP135-10_big_ambitions.pdf).

Overview of our population trends

Notwithstanding our strong vision and ambition, not everyone in our city experiences good health and prosperity, and we are seeing increasing and unsustainable levels of demand for health and care services. Within Leeds, 26% of the population (an estimated 226,000 people), and 34% of children and young people (estimated 60,000 people aged 0-18 years), live within the 10% most deprived areas nationally (or IMD1, the lowest decile in the national Index of Multiple Deprivation). Our Joint Strategic Assessment (JSA, https://observatory.leeds.gov.uk/jsa2021/) provided strong evidence that some inequalities are widening and will worsen following the COVID-19 pandemic. An overview of some of our changing population needs and characteristics as identified through our JSA can be found below**.**

Growing population in our areas of highest deprivation

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

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

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

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

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

Ageing Population

The population aged over 50 has grown by around 30,000 over the last 20 years. This demonstrates a 12% to 17% increase in each of the 50 plus age bands.

Future population growth is predicted to be fastest amongst the 80+ age group which is expected to see a 50% increase over the next 20 years.

The largest concentration of older communities is found within the inner-city areas. The proportion of people living with frailty within the most deprived communities is almost three times higher than those who live in the least deprived.

At age 65, people in Leeds can expect to live half of the rest of their life free of disability or in good health, and half of it with a disability or in poor health.

Population of children and young people growing in our most deprived areas

The child population is growing at a faster rate than the population of Leeds as a whole, but the growth is now concentrated within secondary school-age groups. This population is growing faster in our communities most likely to experience deprivation.

In 2021, almost 24% children were estimated to live in poverty in Leeds compared to 19% nationally. We also know that 34% of children and young people in Leeds live in the 10% most deprived areas nationally.

Between 2016 and 2021 the number of pupils who have an Education Health and Care Plan (EHCP) has more than tripled.

Our city is increasingly diverse

According to the latest 2021 census, the population in Leeds is predominantly white (79%), with non-white minorities representing the remaining 21% of the population. Asian people were the largest minority group in Leeds accounting for 9.7% of the population.

Nearly 200 languages are spoken by children studying in Leeds schools.

63% of Black, 40% of Mixed and 36% of Asian background people living in Leeds live within IMD1 areas, making IMD1 more ethnically diverse than the Leeds average.

An increase in people experiencing mental health issues

The proportion of adults reporting mental health issues increased during the pandemic, with some groups particularly affected including young adults and women; shielding older adults; adults with pre-existing mental health conditions, and Black, Asian, and ethnic minority adults.

These mental health impacts are likely to continue due to the cost-of-living crisis, with concerns about job security and debt levels likely to increase.

People with severe mental illness (SMI) in England are around five times more likely to die prematurely than those that do not have SMI, of which Leeds has been identified as an outlier (UKSHA report).

All these factors, and more, have implications for service provision and Leeds faces a number of significant challenges. The pandemic has driven up demand for health services in most areas above that which we saw before COVID-19 along with significant backlogs. An increase in more complex conditions as well as worsening health inequalities have resulted in an unsustainable growth in demand, further exacerbated by the challenges of recruiting and retaining workforce across the health and care sector. In addition, our health and care system is under significant financial pressure which has been intensified by the current financial climate and cost-of-living-crisis.

Looking at the overall population size and age distribution (excluding deprivation effects) provides an indication of the likely future health and care demand expected in Leeds. The Office for National Statistics (ONS) provides a forecast of the population changes from 2022 to 2028. These forecasts can be combined with our existing data and insight on how much each age group currently uses health and care services and is used to create an age-weighted forecast of the average increase in healthcare demand, which shows likely changes in unplanned care

utilisation (using acute admissions data). Forecasting data also indicates that the population within each deprivation decile is expected to grow but that IMD 1 is expected to grow the highest, and this is more significant within the younger age populations.

To meet our citywide vision, given these challenges, we must start to understand and respond to future population need now. In delivering our Healthy Leeds Plan, we will apply an evidence-based, population health approach to drive innovation and deliver person centred, integrated health and care for the people of Leeds, targeting those who need our support the most. We have also agreed as a Health and Care Partnership to focus our collective efforts toward a few specific goals to really drive change for the people of Leeds.

3. Our Goals

As individual organisations within the partnership, we have priorities that we need to achieve. However, we know that only by working together will we accomplish our individual goals and deliver better outcomes for the people of Leeds. At the centre of our approach is working with people and our Team Leeds health and care workforce to support the partnership. Together we can identify ways to achieve our goals, working better together to identify areas of improvement, and ensuring people and staff feel empowered to make a difference. In developing our collective goals, we believe that:

1. People will be equal partners in their care, ensuring high quality, personalised care services are delivered focusing on what matter to people – we will need to define outcome frameworks based on 'what matters to me'.

2. The population's health overall will move from being sicker and more dependent on services, to living, ageing, and dying well. To do this our Health and Care Partnership will need a much clearer focus on specific goals.

3. For the population's health to improve equitably and for us to reduce health inequalities, our partnership will need to ensure services are more inclusive and better targeted for those who are socially and economically disadvantaged or at higher risk of poor health – our goals must include a focus on reducing inequalities.

4. To achieve our ambition, we will need to shift more resources into prevention and personalised, proactive care – often meaning more activity and care taking place in community settings and people's homes – we will develop measures of how activity levels will change (for some people with a complex physical or mental health condition, the most proactive approach is to have access to specialist care as quickly as possible, which may be delivered from hospital).

Given this, the Leeds Health and Care Partnership has agreed to focus on two collective system goals:

- **Goal 1**: Reduce preventable unplanned utilisation across health settings.
- **Goal 2**: Increase early identification and intervention (of both, risk factors and physical and mental illness).

These goals will focus on the 26% of the population in Leeds who live within the 10% most deprived areas nationally. Taking a person centred preventative and proactive approach – working with people and staff to co-design solutions.

The indicator to measure a reduction in preventable unplanned utilisation within Leeds comprises of four parts:

a. Unplanned acute admissions (bed days)
b. A&E attendances including walk-in and Urgent Treatment Centres (number of attendances)
c. Access to specialist mental health crisis services (number of attendances)
d. Mental health inpatient admissions (bed days)

Preventable unplanned utilisation refers to access or admissions to services where there was scope for earlier or different action to prevent an individual's health or wellbeing deteriorate to an extent where unplanned care services are required. Accessing the right care at the right time, in the right place is what patients, carers (paid and unpaid), families and staff have told us is important to them.

A focus on two goals will help us drive improvements that include:

- **Better outcomes for people**: Patient insight has indicated that people would prefer to access care in a planned rather than an unplanned way. Our data shows that people admitted to hospital in an unplanned way have a longer length of stay compared to those admitted in a planned way. Episodes of unplanned care can also be disruptive for other areas of life such as caring arrangements, work, and education.

- **Better use of resources**: Within Leeds we know that a considerable amount of financial and operational resource is utilised by unplanned care. Given the current financial challenges faced by Leeds and other health systems, resources spent on prevention and early intervention are also likely to reduce costs and increase efficiency.

- **Addressing health inequalities:** Those living in the most deprived neighbourhoods are more likely to utilise healthcare in an unplanned way and less likely to access care in a planned way. We also know from our JSA that the number of people living in IMD1 is expected to grow the fastest in the future.

National and international evidence supports this focussed approach. For example, Staten Island adopted a similar methodology:

Case Study: Staten Island Performing Provider System

In 2014, Staten Island Performing Provider System created an integrated network of providers to improve population health outcomes, reduce costs and reduce avoidable hospital use by 25% over five years. It is comprised of more than 75

provider organisations covering mental health, social care, and community services; 22 population health practices; over 20 community organisations, and 3600 primary care practitioners.

Approach

Staten Island Performing Provider System model utilised a data-driven approach that focussed on a ‘System of Care’ methodology. The Staten Island Performing Provider System created an advanced population health management ecosystem that monitored outcomes of care at an individual, practice, and population level. The platform’s geomapping and hot spotting capability made it possible to correlate geographic areas with services, health outcomes and social determinants of health. The analysis was used to understand risk factors, target interventions and measure success of various projects.

Priority work programmes

The data and insight from the analysis informs the potential programmes of work. Staten Island Performing Provider System, on an annual basis, work with people, local communities, and professionals to review the information and narrow down the potential programmes to a number of focus areas for that year, identifying and co-producing the solutions together. One area of focus was children with asthma. The data indicated that within specific geographic areas there were high numbers of children attending the Emergency Department, longer inpatient stays and much less planned activity compared to children in other areas.

The programme worked with these communities to understand the root causes linked to the higher numbers of children attending unplanned services for asthma. Several solutions were identified which included home visits and working with families and children at higher risk (risk stratification of the population), family hubs within local communities and a focus on eliminating triggers such as pest and mould, including the purchasing of vacuums and mattress covers. The programme resulted in a reduction in the number of Emergency Department attendances and inpatient stays as well as a reduction in the number of lost school days.

Overall achievements of the Staten Island Performing Provider System

The approach used by Staten Island Performing Provider System has delivered significant improvements including, but not limited to:

- 62% reduction in preventable Emergency Department visits, saving $15m
- 61% reduction in preventable mental health Emergency Department visits, saving $6.2m
- 51% reduction in preventable readmissions, saving $6.5m

The Staten Island Case Study shows how starting with a health-based goal has led to numerous examples of improving outcomes and quality of life for people. The success of their paediatric asthma programme resulted in children and their families' lives being less disrupted by not having to frequently attend hospital in an unplanned way.

These focussed goals will help the partnership to target resource, prioritise work and make tangible improvements in the health and wellbeing of people in Leeds, identifying and reducing areas of unmet need in a targeted and systematic way. Concentrating on areas of high cost will also support financial sustainability and allow us to invest further in the upstream, preventative areas that we want to as a system.

Analysis of preventable unplanned utilisation will help inform and understand where, as a system we need to increase early identification and intervention. Therefore, goal two and its supporting measures will be developed at a later stage during 2023 / 2024.

4. Population Health Infrastructure (to support delivery of our goals)

The Leeds Segmentation Model

As a system we are developing robust population health infrastructure, designed to put the diverse needs of our population at the heart of everything we do and move decision-making closer to the people using our services. This infrastructure will help the Leeds Health and Care Partnership to achieve its goals.

Within Leeds we have described the different needs of the Leeds Population using nine mutually exclusive population segments. These nine segments are :

- Children and young people
- Maternity
- Healthy Adults
- People with a learning disability and / or neurodiversity
- Serious Mental Illness
- Cancer
- Long-term conditions
- Frailty
- End-of-life.

Grouping people into segments of similar needs allows us to look at how we use our resources to best meet these needs.

Everyone in Leeds fits in to only one segment at one time reducing the risk of double counting or misrepresenting changes in health outcomes over time. This does not mean we cannot consider population needs across segments, but it does help us to understand the value and impact the partnership has on each segment.

The Leeds Data Model

The Leeds Data Model is our pseudonymised, person level, linked dataset bringing together data from a range of partner organisations delivering health and care to the people of Leeds. The model enables us to identify specific cohorts through our population segmentation model to which we can compare service utilisation, prioritise services and help to plan existing or new services. The Leeds Data Model provides the system with the capability to cross reference utilisation with demographic and geographic information enabling the partnership to plan and deliver initiatives in a targeted and systematic way. Outputs from the Leeds data model was instrumental in the selection of our nine mutually exclusive segments.

Population and Care Delivery Boards

A key element of the Leeds Health and Care Partnership governance structure are the nine population boards that mirror our segmentation approach. These boards have the responsibility for advising and guiding the Partnership on the best way to allocate NHS resources to improve value and reduce health inequalities for its defined population. They have an important role in identifying how to meet local priorities, national priorities and contribute towards narrowing the financial gap. In addition, two ‘care delivery boards’ work across all population segments to understand needs and effectiveness in two critical city-wide areas: Planned Care (elective secondary and community activity); and Same Day Response (same-day urgent and emergency services).

Population and care delivery boards are clinically led and consist of members from each organisation in our partnership. We are also establishing an approach to involving the people of Leeds in the decisions of the boards. Understanding the needs, health outcomes, spend, activity and contracting associated with each population is fundamental to a boards capability to make recommendations.

Population Outcomes Frameworks

Each of the population and care delivery boards have developed an outcomes framework, which clearly sets out what they are working to achieve for their population and how this achievement will be measured. Outcomes have been developed based on insight from people in Leeds as well as wider stakeholder and people engagement. Each board has an insight report that summarises what people have told us about their experiences of care and have been jointly produced with our partners through a series of public involvement workshops (more information here: https://www.healthandcareleeds.org/have-your-say/shape-the-future/populations/). Outcome frameworks continue to be reviewed and revised as further insight is received and the work of the boards evolves. Having clear and measurable outcomes, at a population level, enables us to track outcomes over time and develop an increasing, collective focus on how efficiently or effectively public resources are consumed across all organisations to improve health outcomes.

Local Care Partnerships

Local Care Partnerships bring together a range of partners within Leeds to champion coordinated holistic person-centred care and address community priorities within the context of a wider health and wellbeing partnership. Local Care Partnerships are central in understanding people-voice, insight, and data to help inform decisions and delivery of person-centred care and have a vital role in supporting the wider

partnership to achieve our system goals. The 15 Local Care Partnerships focus on their local communities and implementing solutions to meet the needs of the local community. Local Care Partnerships support the Population and Care Delivery Boards, as well as the Primary Care Board, in achieving the outcomes for their population at a local level.

The work Forum Central has undertaken with the LCP team has ensured that there is a strong third sector presence in all LCPs, connecting communities (both geographical and communities of interest) to local health and care partners.

Read more: https://www.healthandcareleeds.org/about/partners/local-care-partnerships/

Health Inequalities – Tackling Health Inequalities Group and Communities of Interest Network.

The Tackling Health Inequalities Group is an expert advisory group that was established to demonstrate our commitment to achieving our Health and Wellbeing Strategy ambition that the poorest improve their health the fastest with a particular focus on health and care. The Tackling Health Inequalities Group acts as an expert advisory group to the health and care system providing advice, expertise, and challenge to ensure we are taking effective action to reduce health inequalities ensuring a consistent approach and sharing best practice. They have helped the Leeds health and care system to develop its Tackling Health inequalities Toolkit that provides an evidence based and community informed framework for partners to use when addressing health inequalities (https://forumcentral.org.uk/wp-content/uploads/2021/03/DRAFT-Tackling-Health-Inequalities-Toolkit-v8.pdf).

The Tackling Health Inequalities Group has oversight of delivering the requirements of the national Core20PLUS5 (adults) and the Core20PLUS5 (Children and Young People) programmes which are in place to inform action to reduce health inequalities at both a national and system level.

Adults: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Children and young people: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

Whilst the Population and Care Delivery Boards are accountable for addressing health in equalities for their populations, The Tackling Health Inequalities Group has a role to ensure that the health and care system remains focussed on the 26% most

deprived population within Leeds as well as the wider communities that are seldom heard / underrepresented.

In addition, the Communities of Interest Network (COIN, https://forumcentral.org.uk/communities-of-interest/) helps to highlight and address the needs and challenges faced by groups and communities which experience the greatest inequalities. A key focus of the network is to understand and raise awareness of the importance of intersectionality, where people's overlapping social identities may mean they experience multiple disadvantages or discrimination.

Collectively, our Population Health infrastructure forms a central part of the Leeds Health and Care Partnership governance arrangements. The Population and Care Delivery Boards bring key partners in Leeds together so that they can work collaboratively to improve the outcomes, experience and value derived from NHS spend for their defined population. They are supported by the city's expert advisory groups and enablers. Population and Care Delivery Boards provide assurance to the three sub-committees in Leeds that the city is delivering the triple aim of healthcare; improving outcomes, improving experience for people; and ensuring effective use of resource and reporting on performance against the system priorities. These three sub-committees in turn provide assurance to the Leeds Committee of the West Yorkshire Integrated Care Board and subsequently the West Yorkshire Integrated Care Board.

The Partnership Executive Group in Leeds will have oversight of the delivery of our two system goals, with support from the Delivery Sub-Committee, which will have responsibility for monitoring implementation and delivery. The Partnership Executive Group is accountable to the Health and Wellbeing Board and members include the Chief Executives from the NHS in Leeds, Leeds City Council and Public Health, and advocates from the third sector, General Practice and Clinical Senate.

Expert Advisory Groups provide high support high challenge to the boards in areas that are a particular priority for the system:

Person-Centred Care Expert Advisory Group was established through a collective and system commitment to implementing the "Leeds Person Centred Principles". The role of the group is to advise, influence and support implementation of best practice for services which communicate effectively, are compassionate and are coordinated (the Leeds 3 Cs). Within Leeds we support the West Yorkshire vision for everyone to be able to access high-quality health and care services that have been co-designed to take account of lived experiences and personalised through shared decision-making. The care will be responsive to health inequalities, trauma informed, and respectfully delivered, resonating with what matters most to the individual, their family and unpaid carers, and in support of the community connecting them.

The **Leeds Carers Partnership** champions the needs of the estimated 61,500 unpaid carers in Leeds and aims to influence service design and delivery in

response to the needs of carers. Unpaid carers are crucial both to our communities and to the sustainability of health and social care in Leeds. Without unpaid carers, individuals and communities would be worse off and the NHS, social care and community services would be overwhelmed. To achieve our ambition to be the best city for health and wellbeing we need to ensure we can identify and support our unpaid carers, recognise, and value the contribution that unpaid carers make. Alongside this we need to promote unpaid carers' own health and wellbeing, putting unpaid carers at the heart of everything we do, as described within The Leeds Carers Partnership Strategy: https://www.carersleeds.org.uk/wp-content/uploads/2020/11/Leeds-Carers-Partnership-Strategy-DIGITAL.pdf

The Tackling Health Inequalities Group, as described above, provides advice and expertise as well as challenge to the health and care system to ensure we are focussing and taking actions to reduce health inequalities across Leeds. See Health Inequalities section of this plan for more detail.

The **People's Voices Partnership** brings engagement and involvement leads from partner organisations together to share their work. Their common aim is to improve the way we hear the voices of local people, particularly those living with the highest health inequalities. The People's Voices Partnership are working together to understand what matters to people in Leeds. Projects like the Big Leeds Chat have helped senior leaders to listen directly to local people and staff from across the city. The People's Voices Partnership is an expert advisory panel and was instrumental in pulling together the insight reports that our Population and Care Delivery Boards use to understand what matters to the people of Leeds. We have a number of public groups and involvement activities across the city that will help us work together with local people and staff. These groups and activities will enable us to continue listening to people and to use their feedback to shape our services. We are also committed to feeding back to people about how their stories and experiences help us to improve services in Leeds. You can read more about our work to involve people and find out how we are using feedback to shape our services on our Leeds Health and Care Partnership website: https://www.healthandcareleeds.org/have-your-say/examples-of-work/

5. Identifying our strategic initiatives

Measurable improvement toward our goals will be driven by the people of Leeds, clinicians, professionals and the third sector. We will use population health management approaches and local insight (at a Local Care Partnership and city level) to identify, design and implement interventions and service changes that will have the biggest impact on people's health and wellbeing. In line with the Health and Wellbeing Strategy ethos of starting with people and communities, co-production will run through all aspects of change.

Following identification of our system goals to reduce unplanned utilisation and increase early identification, the Office of Data Analytics has developed an initial methodology to identify areas of opportunity to improve health and wellbeing, drawing on the capability of our Leeds Data Model.

Using data from the most recent financial year 2022 / 2023 and focusing on unplanned emergency admission to acute and mental health services, in Leeds or nearby, for those in IMD1, the Office of Data Analytics (ODA) identified the presenting conditions that resulted in the highest rate of unplanned care activity per capita. The age, gender, ethnicity, and location profiles of these groups were then investigated in further detail to identify themes and potential relationships to population segments. For example, identifying a high rate of unplanned care due to injury and falls (as a presenting condition) led to the identification of a cluster of need within the frailty and cancer population segment. This initial methodology (and the assumptions made) were tested within an iterative process, with assurance, validation and challenge from clinicians and subject matter experts at each step.

This methodology will be improved and refined over the next year, including a broader range of metrics from Goal 1 and drawing on more powerful analytical techniques to identify further areas of opportunity. However, the data analysis has indicated several areas for Leeds to consider during 2023 / 2024 as potential areas of focus where we can make a difference and improve outcomes for our population.

These are summarised below:

Children and Young People Population: Diseases of the Respiratory System

The data analysis identified that a significant number of children and young people and their families were impacted by respiratory disease, with a higher prevalence in areas of deprivation. For people living in areas of deprivation the average length of stay, for non-elective bed days, was 2.5 days longer compared to the Leeds average. Through the work of the Children and Young People's Population Board and in developing our health economic approach in Leeds, we know that people under the age of 18 are demonstrating the fastest population growth within IMD 1 areas in Leeds. Therefore, investment in prevention for this population group is important to support them in leading healthy lives in the future.

People with three or more Long Term Conditions and Serious Mental Illness

We know, through data analysis, that this cohort of people utilise a high number of non-elective bed days, coupled with a high prevalence of known risk factors. For example, we know that 60% of this cohort are obese and 32% smoke. We also know, through evidence-based methodologies, that these conditions area amenable to improvement via person centred proactive care.

Serious mental illness and multiple Long-Term Conditions (LTCs) are plus groups, as defined within the national Core20PLUS5 Programme. Three of the five clinical areas identified within the Core20PLUS5 programme that require accelerated improvements are workstreams within the Serious Mental Illness Population Board and the Long-Term Conditions Population Board.

Frailty and Cancer Populations: Injury / Fracture

Despite significant focus and investment in this area as a city, data demonstrates that injuries and fractures remain a challenge for the older population in Leeds even though improvements have been seen. Data analysis indicated that a large proportion of unplanned bed days were occupied by older people with an estimated average length of stay at nine days. For people living within areas within IMD 1, our most deprived areas, the average length of stay, following an injury or fall, was 5.5 days longer than people living in other areas of Leeds.

This analysis is also replicated within the population of people living with cancer, where we know that a significantly high proportion, 79%, are living with cancer and frailty and have experienced non-elective admission as a result of an injury / fracture. It is therefore proposed that the Cancer Population Board and the Frailty Population Board work together on this strategic initiative.

End of Life Population: Diseases of the Respiratory System

The End-of-Life population segment is our smallest population segment in size but represents the fourth highest number of bed days in total with the highest rate of bed days per 1,000 population. The rate of bed days per 1,000 population is higher for the people living within the more deprived areas of Leeds. With the projected growth in the population of Leeds who are over 80 years it is important that we understand and address this utilisation. This strategic initiative will be taken forward through the End of Life Population Board with input from the Long Term Conditions and Frailty Population Boards.

Intermediate Care Provision: HomeFirst Programme

Alongside the strategic initiatives, the partnership has agreed an area of focus on improving wider system flow, which directly links to achieving goal one. Every day in Leeds thousands of people receive great care and support from dedicated health and care staff, volunteers, and unpaid carers. However, there are opportunities for us to improve people's outcomes. We know:

- Too many people spend more time in hospital than they need to.
- Our short-term care in the community is provided across many different services.
- Outcomes for people can vary depending on where, when, and how they are supported.
- We have a high use of bed-based care.
- Many older people could reduce or avoid deconditioning that has an impact on their interdependence and long-term care needs.

The HomeFirst Programme represents our fifth strategic initiative for the partnership. This programme is developing and implementing a new model of intermediate care services to address the challenges described above, achieving more independent and safe outcomes for people, unpaid carers and staff. By delivering improvements in five project areas (Active recovery at home, Enhanced care at home, Rehab and recovery beds, Transfers of care and System visibility and active leadership) it is expected to create real change for the people of Leeds, within measurable improvements in the following areas:

- ✓ 1,700 fewer adults admitted to hospital.
- ✓ 800 fewer people spending days in hospital.
- ✓ 400 more people going directly home after their stay in hospital.
- ✓ 1,200 people benefitting from a more rehabilitative offer in their own home.
- ✓ 400 people able to get home sooner form a short-term bed.
- ✓ 100 more people able to go home after their time in intermediate care (all year vs. a 2022 baseline)

Through the initial work of the HomeFirst Programme we know that 30% of the most deprived areas within Leeds account for 42% of intermediate care patients. On average, those patients living in IMD 1 are typically more frail and younger than the users living within other areas. People living with dementia are at least twice as likely to access intermediate care as the average person over 80 years or the frailty population. Patients living with dementia have a higher re-admittance rate to hospital following discharge from the Neighbourhood Teams or Community Care beds. We also know that in Leeds people living with dementia have a disproportionate use of unplanned utilisation, particularly non-elective bed days and this is higher for those people living in IMD 1.

Financial Sustainability

Leeds health and care partners will be unable to achieve its goals and deliver on the Health and Wellbeing vision if it doesn't also maintain financial stability. Our financial plans for 2023 / 2024 are built on the premise that the city can achieve substantial in-year savings. The Leeds Integrated Care Board budget has grown over recent years by 34.5%, however spending on provision has grown even more – between 42% and 58% with our three main NHS providers in Leeds. Much of this spending has been on a recurrent basis and as such this has created an underlying deficit to the system that needs addressing. This change has three root causes:

1. Through COVID-19 the NHS rightly received a lot of additional funding, and this has now been withdrawn at a faster pace than the services (and staff) that were put in place.
2. The pandemic has driven up demand for health services in most areas above that which we saw before COVID-19 along with significant backlogs.
3. The cost of living whether in the cost of utilities or indeed well-deserved staff pay rises has also impacted as these have not been fully covered nationally.

Therefore, a focus on our priorities as described above must not only improve outcomes and experience for people but it must also lead to a better use of resources and contribute towards closing the financial gap within the NHS, as well as considering the considerable pressures within our wider partnership such as social care and other non-statutory providers. Responsibility for closing the financial gap is owned by the Leeds Health and Care Partnership. It is important that financial decisions are made in line with our system strategy and that a collective feeling of financial stewardship is fostered within the system, particularly within our Population and Care Delivery Boards, to support Leeds in reaching financial sustainability.

With this aim, our Population and Care Boards will play an important role in identifying, evaluating, and overseeing the implementation of the savings that need to be made. The people on these boards and their colleagues are the people closest to the services and their population. These boards have the knowledge and insight to drive better value for our Leeds pound.

Annual Priority Cycle

Ensuring success of a focussed approach, as demonstrated by Staten Island model, is not just about the goals themselves but the behaviours that focussing on a goal has led to. Within Leeds we have developed a partnership approach to an annual cycle based on the Staten Island model.

A small number of data-informed priorities, which link to our system goals, will be identified, and reviewed each year by our partnership and will be informed by data,

insight and evidence. For each priority area identified we will collaborate with people, communities, and staff to really understand the root cause of the problem and work together to identify the solutions, whether these are health based or linked to the wider determinants. Solutions may be at a system level, population level or within our local communities. We will work together to monitor the impact of interventions and actively respond if the anticipated impacts are not being realised. In undertaking this planning approach, we will always:

1. Plan care by understanding the clinical and financial risk profile of specific population groups to inform interventions and investment priorities, particularly in prevention.
2. Improve equity of access and reduce unwarranted variations in health and care services.
3. Target interventions to those who need it most by identifying people at risk of poor outcomes earlier.
4. Design and deliver how and where people receive health and care services, ensuring care is closer to their home, their family or community and that people remain in Leeds, by embedding a ‘home first’ approach and ensuring people have the tools, knowledge, and skills to self-care.
5. Connect and integrate care and information across pathways, services, and teams, where it makes sense, through new hospitals, redesigned intermediate care offer and improved community and primary care offer.

6. Our Plans

Our Population and Care Delivery Boards are the focal point for delivery of the priorities identified above. They are also responsible for supporting the local delivery of West Yorkshire and National NHS priorities. These come together within the individual board plans, included in the following pages. Each plan describes the vision, outcomes, and priority work programmes for each board (e.g., by population segment), and how these will drive improvements in our city's goals, support West Yorkshire ambitions and ensure delivery of Long-Term Plan priorities, including COVID-19 recovery plans across Urgent and Emergency Care Recovery; Elective Recovery; and Primary Care Recovery.

There are two programmes of work that link to the West Yorkshire 10 Big Ambitions but are not aligned to a specific Population or Care Delivery Board and these are Suicide Reduction and Antibiotic Resistance and are described first.

The appendices provide the detailed operational plan for how the partnership will meet the 31 national objectives and locally defined population through a wide range of individual projects.

Suicide Reduction

Our Suicide Prevention Plan: https://observatory.leeds.gov.uk/wp-content/uploads/2020/02/DRAFT-Refresh-Suicide-Prevention-Action-Plan-for-Leeds-2020.pdf

With the responsibility of suicide prevention resting with local authorities, Leeds City Council's public health team leads our multi-agency citywide suicide prevention strategic group, which contributes to suicide prevention work across West Yorkshire, supported and guided by real time surveillance of suspected suicides from West Yorkshire Police. It is a working document, used as framework to guide local action and activity, and is informed by local and national policy and evidence for suicide prevention, including:

- Audit of Suicides in Leeds (2014 – 2016, https://observatory.leeds.gov.uk/wp-content/uploads/2019/09/Leeds-Suicide-Audit-2014-2016-Full-Report.pdf)
- Preventing Suicide in England reports (https://observatory.leeds.gov.uk/wp-content/uploads/2019/09/Leeds-Suicide-Audit-2014-2016-Full-Report.pdf).

The local plan brings strategic partners across healthcare and wider settings to ensure the best use of limited resources, and is being delivered through six workstreams:

1. Citywide leadership for suicide prevention.

2. Reduce the risk of suicide in high-risk groups.
3. Develop and support effective suicide prevention activity in local primary care services.
4. Provide better information and support to those bereaved or affected by suicide.
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour; and
6. Improve local intelligence on suicide in Leeds to inform suicide prevention activity.

The latest Leeds Suicide Audit (due for completion summer 2023), using data from the coroner's office, will provide details on demographics, risk factors and details of access to services for all Leeds residents of suicides between 2019 and 2021 and will help further target interventions to reduce risk. The audit will also support the development of new, co-produced recommendations for actions and a new Suicide Prevention Action Plan for the city. The Suicide Prevention Action Plan sits within the context of the wider public mental health programme. Other priorities in this programme include mental health promotion and wellbeing; reducing stigma and discrimination; and effective, equitable mental healthcare services.

Antibiotic Resistance

Leeds is part of the wider West Yorkshire Health and Care Partnership Integrated Care System Antimicrobial Resistance Steering Group, with a place-based stewardship group. The Leeds Antimicrobial Stewardship Group was developed in 2016 with a range of partners from across the Leeds Health and Care System. We have also developed a local, place based, collaborative and system wide approach to address antibiotic resistance in Leeds with a clear action plan which is monitored through the Leeds Antimicrobial Stewardship Group. The plan has three key priorities and aligns to the National Action Plan on Antibiotic Resistance and the West Yorkshire Antimicrobial Strategy:

- Reducing the need for and unintentional exposure to antibiotics.
- Optimising use of antibiotics.
- Investing in innovation supply and access.

Children and Young People (CYP) Population

Population size: 177,712 people, includes all Leeds residents under the age of 18.

Children and Young People Population Outcomes:

- Children are safe from harm.
- Children do well at all levels of learning and have skills for life.
- Children in Leeds are healthy.
- Children are happy and have fun.
- Children and young people in Leeds are active citizens who feel they have a voice and influence.

Key workstreams:

- **Keeping children safe from harm**
  - Compassionate Leeds supports the most vulnerable and addresses impact of trauma and adverse life experiences.
- **Children with complex needs**
  - Neurodiversity identification, assessment and support review
- **Addressing health inequalities in children and young people**
  - Core20PLUS5 action plan
- **Childrens Mental Health**
  - Crisis offer for CYP from prevention to inpatient stays.
- **Children's system flow**
  - Develop proactive and reactive model to ensure children are seen at the right time in the right.

Link to NHS National Priorities

Improve access to mental health support for children and young people (0-25 years).

Link to Core20PLUS5

Focus on the most deprived communities and plus groups asthma, diabetes, epilepsy, oral health, and mental health.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

- Address the health inequality gap for children living in households with the lowest income, including halting the trend in childhood obesity.
- Reduce the gap in life expectancy between people with mental health conditions, learning disabilities, and / or autism, and the rest of the population. In doing this we will focus on early support for children and young people.

Link to West Yorkshire Programmes

Supporting our children, young people and families

Link to Leeds Health and Wellbeing Strategy (2023-2030):

- A Child Friendly and Age Friendly City where people have the best start and age well.
- Safe and sustainable places that protect and promote health and wellbeing.
- A mentally healthy city for everyone

Link to local strategies and plans

- The Future In Mind Strategy
- Compassionate Leeds Strategy
- Child Friendly Leeds
- Leeds Children and Young People's Plan
- Best Start Strategy
- Early Help Strategy
- Nesta partnership
- Attainment Achievement and Attendance strategy
- Thriving strategy
- Leeds Play Strategy
- Leeds Food Strategy

Maternity Population

Population size: 12,777 people includes people over 18 and pregnant, or within two years of a pregnancy.

Maternity Population Outcomes:

- Families and babies are supported to achieve optimal physical health.
- Families and babies are supported to achieve optimal emotional health.
- People receive personalised maternity care safely.
- People feel prepared for parenthood.

Key workstreams:

- **Maternity dashboard quality surveillance**
    - Review utilisation, safety and risks.
    - Monitor workforce and retention.
    - Bookings before ten weeks.
- **Maternity and Neonatal Voices Partnership**
    - Accessible and close to home care service user engagement.

    - Staff satisfaction and feedback
- **Gestational diabetes and maternal healthy weight**
    - Targeted healthy eating and physical activity interventions.
    - Infant feeding support.
    - Future pregnancy planning education.
    - Community based peer support sessions for diabetes and unhealthy weight.
- **Health inequalities**
    - Review of interpreter service within maternity including digital access.
    - Accessible and closer to home care.
    - Young parents and doula service offer and support.
- **Perinatal and maternal mental health**
    - Service offer to combine maternity, reproductive health, and psychological therapy.
    - Increase access to perinatal and maternal mental health services.
- **People feel prepared for parenthood**
    - Perinatal parenting programmes.
    - Breastfeeding.
    - Baby steps.
    - Infant mental health.

Link to NHS National Priorities:

- Make progress towards the national safety ambition to reduce still birth rate, neonatal mortality, maternal morality, and serious intrapartum injury.
- The NHS will continue to contribute towards levelling-up, through its work to tackle health inequalities showing a continued reduction in the difference in the stillbirth and neonatal mortality rate between that for Black, Asian, and Minority Ethnic women and the national average.
- Listening to and working with women and families with compassion.
- Growing, retaining, and supporting our workforce.
- Developing and sustaining a culture of safety, learning and support.
- Standards and structures that underpin safer, more personalised, and more equitable care.

Link to Core20PLUS5:

- Focus on the most deprived communities and plus groups.
- Maternity: Ensuring continuity of care for women from Black, Asian, and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions

Reduction in stillbirths, neonatal deaths, brain injuries

Link to West Yorkshire Programmes

Maternity services

Link to Leeds Health and Wellbeing Strategy

Promoting prevention and improving health outcomes through an integrated health and care system

Link to local strategies and plans

- Leeds Maternity Strategy
- Child Friendly Leeds
- Ockenden Review
- Maternity Transformation Programme

Healthy Adults Population

Population size: 343,243 people includes people, aged 18 and over with no diagnosed long-term condition and not pregnant.

Healthy Adults Population Outcomes:

- People in Leeds are mentally healthier for longer.
- People in Leeds are physically healthier for longer.
- People in Leeds are supported to live well and have a standard of living which supports their health and wellbeing.

Key workstreams:

- **Healthy Mind** –
    - Data led approach to targeted interventions for those at greatest risk of developing anxiety, depression, and risk of suicide.
- **Healthy Body**
    - Data led approach to targeted interventions for those at greatest risk of developing hypertension, diabetes, liver disease and osteoarthritis.
- **System Flow**
    - Out of hospital project for those with no fixed abode / multiple complex disadvantages.
    - Social prescribing in A&E.
    - Home Plus service.
- **People supported to live well**
    - Social prescribing for non-clinical health and wellbeing needs.
    - Social prescribing in A&E.
    - Digital health hubs.

- **Tackling Health Inequalities (Core20PLUS5)**
    - Community grants schemes via Local Care Partnerships (LCPs).
    - Development of Core20PLUS5 data lenses for all boards.
    - Development of models best practice to design and implement interventions to tackle inequalities.
- **Health Inclusion**
    - Outreach, advocacy, and access – focussed support and intervention for the most vulnerable and at risk cohorts (sex workers, Gypsy and Travellers, refugee and asylum seekers, homelessness, offenders).

Link to NHS National Priorities:

- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals (specifically weight management for this population)
- The NHS will invest in prevention to improve health outcomes.

Link to Core20PLUS5:

Focus on the most deprived communities and plus groups.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

- We will increase the years of life that people live in good health.
- Address the health inequality gap for children in poverty, including halting the trend of childhood obesity.
- Increased early cancer diagnosis rates.
- Reduce suicide by 10%.

Link to Leeds Health and Wellbeing Strategy:

- A city where everyone can be more active, more often.
- Improving housing for better health.
- A mentally healthy city for everyone.
- Promoting prevention and improving health outcomes through an integrated health and care system.

Link to local strategies and plans

- Leeds Drug and Alcohol strategy
- Leeds Best City Ambition (https://www.leeds.gov.uk/plans-and-strategies/best-city-ambition)
- Inclusive Growth Strategy
- Marmot City Ambition

People with a Learning Disability and / or Neurodiversity Population

Population size: 5180 people, includes all people with a diagnosis of a learning disability and / or autism.

People with a Learning Disability and or Neurodiversity Population Outcomes:

- Appropriate early identification of a Learning Disability and / or neurodivergence
- Prevention of LTC within this population through a focus on keeping healthy.
- Early detection and proactive support around the management of LTCs within this population.
- Learning disability, Autism, and ADHD acceptance in Leeds with a focus on services making reasonable adjustments and better meeting the needs of this population.

Key workstreams:

- Reducing reliance on inpatient care for people with a learning disability and / or autism.
- **Step Up Crisis** - alternative review and redesign to provide an alternative to hospital assessment and treatment and a proactive means of preventing placement breakdown.
- Review and improve integrated pathways for diagnosis, treatment, and support for autistic people and people with ADHD.
- Improve access to and uptake of mainstream health services responding to the Health Facilitation Team evaluation, Autism access project outputs.
- Accuracy of GP registers and increase uptake of annual health checks.

Link to NHS National Priorities:

- Reduce reliance on inpatient care, while improving the quality of inpatient care, for adults and children with a learning disability and / or who are autistic.
- Continue to increase the number of people aged over 14 on the GP learning disability register receiving an annual health check and health action plan.
- Improve access to and uptake of mainstream health services:
    - The LeDeR programme (Learning from Lives and Deaths)
    - Learning from lives and deaths, people with a learning disability and autistic people.
    - Digital Reasonable Adjustment Flag

Link to Core20PLUS5:

- Focus on the most deprived communities and plus groups.

- Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability and / or autism.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and / or autism.

Link to West Yorkshire Programmes:

Mental Health, Learning Disabilities, and Autism

Link to Leeds Health and Wellbeing Strategy:

- A mentally healthy city for everyone.
- The best care in the right place at the right time.
- Promoting prevention and improving health outcomes through an integrated health and care system.

Link to local strategies and plans

- Being Me strategy
- Leeds Autism strategy

Serious Mental Illness Population

Population size: 12,452 people, includes all people over 18 years old with a diagnosis of Serious Mental Illness.

Serious Mental Illness Population Outcomes:

- People in Leeds with a serious mental illness receive care at the right time and in the right place.
- People in Leeds are proactively supported within the community.
- People in Leeds have timely access to crisis support.
- People in Leeds are discharged in an appropriate, timely and supported way.

Key workstreams:

- **Community Mental Health Transformation**
    - Design and implement a new model of care with PCNs and LCPs that responds to local needs and removed barriers to access so people can access care, treatment, and support as early as possible and be supported to live as well as possible in their community.
    - Further develop outreach and pathways to improve access to physical health checks and interventions for those with SMI.

    - Further improve and develop the early intervention in psychosis pathway, providing access to evidence-based interventions for those with at risk mental states (ARMS)
- **Reducing inappropriate out of area mental health bed days**
    - Mental health discharge challenge event with focus on peer support discharge workers and Acute Care Excellence (reducing unnecessary clinical variation, improving quality of acute impatient provision)
- **Mental health crisis**
    - Redesign of simplified access to MH crisis.
    - Embedding NHS 111 into this local crisis redesign.
    - Optimising value of MH spend through review of outcomes, experience and value of current MH crisis pathway, including responding to the evaluation of the community bases crisis house two-year pilot with LYPFT crisis team to reduce admissions for people with acute MH crisis support needs.
    - Implementation and evaluation of new delivery model for street triage.

Link to NHS National Priorities:

- Increase the number of adults and older adults accessing IAPT treatment.
- Increase in the number of adults and older adults supported by community mental health services.
- Work towards eliminating inappropriate adult acute out of area placements.
- Improve access to perinatal mental health services.

Link to Core20PLUS5:

- Focus on the most deprived communities and plus groups.
- Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

- Achieve a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities, and / or autism.
- Achieve a 10% reduction in suicide rates.

Link to West Yorkshire Programmes:

Mental Health, Learning Disabilities and Autism

Link to Leeds Health and Wellbeing Strategy:

- A mentally healthy city for everyone.
- Strong, engaged, and well-connected communities.
- The best care in the right place at the right time.

Link to local strategies and plans:

Leeds Mental Health Strategy

Cancer Population

Population size: 27,806 people, includes all people with a diagnosis of cancer.

Cancer Population Outcomes:

- People living with cancer will receive person centred care.
- More cancers will be prevented.
- People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial.
- People will receive the safest and most effective cancer treatments that are available.

Key workstreams:

- **Person centred care**
  - Two weeks wait (2ww) frailty assessment clinics.
- **Screening, prevention, and awareness**
  - Leeds health awareness services with a focus on deprived and culturally diverse communities.
  - Primary care screening champions within 45 most deprived practices.
  - Lung fit health checks.
- **Earlier diagnosis**
  - Open access chest x-ray for people concerned about lung cancer symptoms.
  - Implement Faecal Immunochemical Testing (FIT) testing within the lower GI pathway.
  - Primary care Directed Enhanced Services (DES) to reduce ‘did not attend’ (DNAs) and improve 2ww pathway.
  - Pinpoint blood test evaluation.
  - New camera equipment within community tele-dermatology.
  - Increase training for practice nurses to request chest x-ray.
  - Increase non-specific symptoms pathway.
  - Develop new oral lesions pathway.
- **Living with, and beyond cancer**
  - Risk stratified pathways and development of digital remote monitoring systems.
  - End of treatment summaries to support people and recognise any signs to be aware of.
  - Develop robust and safe demobilisation plan for current community cancer support service and look at alternative provision within the community.

Link to NHS National Priorities:

- Increase rate of cancer cases diagnosed at stage 1 or 2.
- Reduce the number of people waiting longer than 31 and 62 days for treatment.
- Meet the 28-day Faster Diagnosis Standard.
- Cancer screening targets (bowel, breast, lung and cervical)
- Improve one year cancer survival rates.

Link to Core20PLUS5:

Earlier cancer diagnosis.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

- Increase the years of life that people live in good health.
- Increased early diagnosis rates for cancer, ensuring at least 1,000 more people will have the chance of curative treatment by 2024.

Link to Leeds Health and Wellbeing Strategy:

- The best care in the right place at the right time.
- Promoting prevention and improving health outcomes through an integrated health and care system.

Link to local strategies and plans

- Leeds Cancer Programme
- Leeds Teaching Hospital NHS Hospitals Trust Cancer work
- West Yorkshire Cancer Alliance

Long-Term Conditions Population

Population size: 242,528 people, includes all people over 18 years with a diagnosis of qualifying long-term condition and not in any other segment.

Long-Term Conditions Population Outcomes:

- People living with a long-term condition get the support and tools they need to be as healthy and well as they can be.
- People with a long-term condition return to and maintain their normal activities and lifestyle in ways that matter to them.
- People with a long-term condition take an active role in managing their condition

Key workstreams:

- **Integrated weight management**
    - Integrated weight management model development.
    - Nutrition and dietetics / enteral feeds / oral nutritional supplements.
- **Multi-morbidity** (three or more long term conditions plus serious mental illness).
    - Develop secondary prevention MDT / multimorbidity hub ambition.
    - Long COVID review.
    - Rehabilitation model development.
    - Self-management.
    - Cardio-renal-metabolic (CaReMe)
    - Digital remote monitoring.
- **Cardiovascular Disease (CVD)**
    - Lipids Maintenance Hypertension.
    - Remote monitoring / self-management.
    - Anticoagulation and thrombosis.
    - Integrated Heart Failure model next steps.
- **Respiratory**
    - Home Oxygen delivery across Yorkshire and Humber.
    - Community intravenous service (CIVAS).
    - Diagnosis and prescribing.
    - Asthma prescribing.
    - Spirometry and contribution to diagnostic hubs.
- **Neurology**
    - Stroke.
    - Community Neurological Rehab Service (CNRS) redesign.
    - Multiple sclerosis (MS), Epilepsy, Functional Neurological Disorder (FND) and Motor Neurone Disease (MND).
- Diabetes
    - National Diabetes Prevention Programme (NDPP).
    - Diabetes Remission.
    - NHS Treatment and Care performance.
    - Chronic Kidney Disease (CKD)
    - Continuous Glucose Monitoring (CGM

Link to NHS National Priorities:

- Increase percentage of patients with hypertension treated to NICE guidance.
- Increase the percentage of patients aged 25 - 84 years with a cardiovascular disease (CVD) risk score greater than 20% on lipid lowering therapies.
- Increase the number of people supported via the NHS diabetes prevention programme – reflecting the NHS's contribution to wider government action to reduce obesity prevalence.

Link to Core20PLUS5:

- Focus on the most deprived communities and plus groups.
- To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.
- Address over reliance on reliever medications; and decrease the number of asthma attacks.
- Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

We will increase the years of life that people live in good health.

Link to West Yorkshire Programmes:

Supporting Long Term Conditions.

Link to Leeds Health and Wellbeing Strategy:

- A city where everybody can be more active, more often.
- Promoting prevention and improving health outcomes through an integrated health and care system.
- Support for carers and enable people to maintain independent lives.
- A mentally healthy city for everyone.

Link to local strategies and plans

- Leeds Diabetes Strategy: https://www.leedsccg.nhs.uk/wp-content/uploads/2019/04/Leeds_Diabetes_Strategy_2019-24.pdf
- Leeds Stroke Priority Report: https://www.healthandcareleeds.org/wp-content/uploads/2023/02/2023_01_Stroke_Priorities_Final_AS_v2.pdf

Frailty Population

Population size: 62,381 people, includes any person over 60 and with an electronic Frailty Index sore greater than 5.

Frailty Population Outcomes:

- Living and ageing well defined by ‘what matters to me’.
- Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer
- Reducing avoidable disruption to people’s lives as a result of contact with services.

Key workstreams:

- **HomeFirst Programme**
  - Review of intermediate care services and pathways / processes to reduce delays.
- **Dementia needs**
  - Coordinateeed dementia action plan to identify, support and manage more complex need.
- **Virtual Ward**
  - Hospital at Home.
  - Remote monitoring.
- **Reactive Care**
  - Urgent community response.
  - Falls response.
  - Falls prevention.
- **Proactive Care**
  - Anticipatory care falls strength and balance.

Link to NHS National Priorities:

- Two-hour Urgent Community Response (UCR).
- Virtual ward capacity.
- Reduce general and acute bed occupancy.
- Reduce the number of medically fit to discharge patients in our hospitals (and community provision).
- Recover the dementia diagnosis rate.

Link to Core20PLUS5:

Focus on the most deprived communities and plus groups.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

We will increase the years of life that people live in good health.

Link to West Yorkshire Programmes:

Supporting people leaving hospitals and developing integrated step-up and step-down intermediate care services.

Link to Leeds Health and Wellbeing Strategy:

- Promoting prevention and improving health outcomes through an integrated health and care system.
- Support for carers and enable people to maintain independent lives.
- The best care in the right place at the right time.
- A mentally healthy city for everyone.

Link to local strategies and plans:

Age Friendly Leeds

End-Of-Life Population

Population size: 3095 people, includes all people over 18 years and on palliative care register.

End-of-Life Population Outcomes:

- People approaching the end of their life are recognised and supported on time.
- People approaching the end of life live and die well according to what matters to them.
- All people approaching the end of life receive high quality, well-coordinated care at the right place at the right time and with the right people.
- People approaching the end of life and their carers are able to talk about death with those close to them and in their communities. They feel their loved ones are well supported during and after their care.

Key workstreams:

- Enhance initiatives and capacity to raise community awareness and address barriers to care and support including linkage and analysis of routinely collected data, alongside targeted inquiry, to inform strategic action.
- Enhance earlier identification and recognition of people approaching the end of their life in Leeds, utilising digital needs identification, to enable timely and effective support to patients, families, carers, and communities.
- Improve the uptake and quality of digital Advanced Care Plans (Planning Ahead), including the interoperability of digital ACPs across providers, to facilitate high quality coordinated care.

- Continue to improve pathways and integration for end of life care across and within all providers with particular focus on out of hospital provision and effective use of acute hospital services.
- Maintain and enhance 24/7 access to care, support, advice, and guidance across all settings in Leeds.
- Maintain the coordinated education and training provision for end-of-life care professionals in Leeds targeting areas of identified need.

Link to Core20PLUS5:

Focus on the most deprived communities and plus groups.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

We will increase the years of life people live in good health.

Link to West Yorkshire Programmes:

Palliative and end of life care.

Link to Leeds Health and Wellbeing Strategy:

- The best care in the right place at the right time.
- Support for carers and enable people to maintain independence.

Link to local strategies and plans:

Leeds Adult Palliative and End of Life Care Strategy 2021-2026:
https://www.leedspalliativecare.org.uk/seecmsfile/?id=132

Same Day Response Care Delivery Board

Those accessing ‘on the day’ urgent services.

Outcomes:

- People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs
- People’s same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.
- Care is high quality, person-centred and appropriate to people’s same day care needs now, whilst considering how these might change in the future.

Key workstreams:

- **Primary Care Advice Line Plus:**
    - Creating a new single gateway: working with Yorkshire Ambulance Service to identity and ‘push’ referrals to Urgent Community Response (UCR) via Single Point Urgent Referral (SPUR) as clinically triaged from ambulance stack and assessing impact of primary / community clinicians ‘pulling’ from the stack and providing UCR.
- **Children urgent care**
    - Paediatric Acute Respiratory Infection (ARI) hub – Leeds Community Ambulatory Paediatric Service (CAPS) for Children requiring physical examination for respiratory symptoms.
- **24 / 7 integrated Primary Care Services**
    - Same Day Primary Care services.
    - Integration between services across the 24hr period.
    - Digital access to support same day.
- **Maximise Primary Care Advice Line and develop same day emergency care**
    - Avoid unnecessary ED attendances by facilitating healthcare providers to get people to the right place for their care.
- **Urgent Community Response**
    - Two-hour crisis response offer.
    - Telecare Rapid Falls response.
    - Virtual wards (hospital at home and remote monitoring).

Link to NHS National Priorities:

- Improve A&E waiting times to align with 4-hour target, reduce 12-hour waits.
- Improve category 2 ambulance response times to an average of 30 minutes.
- Reduce adult general and acute (G&A) bed occupancy levels.
- Step up out of hospital capacity including Virtual Ward Capacity.

Link to Core20PLUS5:

Focus on the most deprived communities and plus groups.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

We will increase the years of life that people live in good health.

Link to West Yorkshire Programmes:

Same Day Emergency Care.

Link to Leeds Health and Wellbeing Strategy:

The best care at the right place at the right time.

Link to local strategies and plans:

- NHS planning submission for same day response

Planned Care Delivery Board

Includes anyone being referred for, or awaiting a planned care procedure, treatment, or appointment either in a community or hospital setting.

Outcomes:

- Planned care services are accessible to all regardless of who they are.
- People are supported whilst waiting for all planned care services.
- People agree appropriate and realistic shared health goals, and actively participate in their achievement.

Key workstreams:

- **Managing capacity and elective care recovery**
    - Community Gynae re-design.
    - Procurement Community Ophthalmology Services.
    - Procurement ENT and Adult Hearing Loss Services.
    - COVID Urgent Eyecare Service (CUES).
    - Procurement of Community Gastro / Endoscopy services
    - MSK Service Review.
- **Earlier Diagnosis**
    - Implementation of Leeds Community Diagnostic Centres.
    - Direct access to diagnostics understanding uptake and variation across Leeds.
- **Waiting support**

    - Waiting Well for Planned Care – support provided by Care navigator / support workers targeting people in the most deprived areas and working with PCNs that have highest utilisers of A&E whilst waiting for planned care.
    - Shape up for Surgery care navigator / support worker expansion to ensure patients are optimised for surgery / treatment with a focus on the most deprived areas.
- **Outpatients redesign**
    - Expansion of Advice and Guidance.
    - Increase use of Patient Initiated Follow up (PIFU).
    - Reduction in outpatient follow up.

Link to NHS National Priorities:

- Eliminate waits of over 65 weeks for elective care (except where patients choose to wait longer or in specific specialties).
- Deliver the system specific activity target.
- Increase the percentage of patients that receive a diagnostic test within six weeks.
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.
- Performance against 18-week Referral to Treatment waiting time standard.

Link to Core20PLUS5:

Focus on the most deprived communities and plus groups across core clinical areas.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

We will increase the years of life that people live in good health.

Link to West Yorkshire Programmes:

Recover and transform planned care services.

Link to Leeds Health and Wellbeing Strategy:

- The best care in the right place at the right time.
- An inclusive, valued, and well-trained workforce.
- Promoting prevention and improving health outcomes through an integrated health and care system.

Link to local strategies and plans:

- NHS planning submission for planned care, diagnostics, and outpatients.
- Leeds Teaching Hospital NHS Trust Transformation Programmes across Diagnostics, Planned Care and Outpatients.

Primary Care

Outcomes:

- Improved care experience for people, with patients receiving appropriate and timely access, advice and care.
- Improved health outcomes
- Reduced health inequalities.
- An improved work experience for staff, volunteers, and carers

Key workstreams:

- **Optimising access to primary care**
    - Implementation of the Primary Care Access Recovery Plan with a focus on cloud-based telephony, review capacity and demand models of care and new online consultation system and expanding the role of community pharmacy.
- **Cardiovascular Disease prevention and diagnosis**
    - Quality improvement across the Primary Care Network to address:
        - identification of hypertension
        - detection and management of atrial fibrillation (AF)
        - addressing cholesterol in the context of CVD risk, including detection and management of familial hypercholesterolaemia (FH).
        - earlier diagnosis of heart failure
- **Annual health checks for people with a learning disability**
    - With a focus on those patients that have not received an annual health check in previous 18 months.
- **Tackling neighbourhood health inequalities**
    - Focussing on meeting unmet need at a local community level (PCN / LCP).
- **Dementia diagnosis**
    - Practices to review dementia prevalence rate and identify patients at clinical risk of dementia and offer assessment and referral.
- **Personalised care**
    - Targeted programme of social prescribing to an identified cohort with unmet need.

Link to NHS National Priorities:

- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
- Continue the trajectory to deliver more appointments in general practice.

- Increase the workforce (recruit 26,000 (515wte for Leeds) Additional Roles Reimbursement Scheme by March 2024
- Support the Health and Wellbeing of the Workforce through supporting the Quality and Outcomes Framework (QOF) Quality Improvement module.
- By 30 June 2023, PCNs to develop an access improvement plan which will improve patient experience of contacting their practices and being assessed and / or seen within the appropriate timeframe (for example same day or within 2 weeks where appropriate).

Link to Core20PLUS5:

Focus on the most deprived communities and plus groups.

Link to West Yorkshire Integrated Care Boards 10 Big Ambitions:

- We will increase the years of life that people live in good health.
- Address the health inequality gap for children living in households with the lowest incomes.
- 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and / or autism.

Link to West Yorkshire Programmes:

Primary Care Transformation

Link to Leeds Health and Wellbeing Strategy:

- The best care in the right place at the right time
- Support for carers and enable people to maintain independent lives.
- Promoting prevention and improving health outcomes through an integrated health and care system

Link to local strategies and plans:

- Gore GP Contract
- Fuller Stocktake
- Access Recovery Plan
- PCN Directed Enhanced Service

6. Enablers

For Leeds to achieve the goals of the Healthy Leeds Plan and the vision of the Health and Wellbeing Strategy, it will need to harness the power of our city-wide enablers – building blocks for a transformative health and care system. These include our capabilities around workforce, research and academia, communication and involvement, leadership and culture, data, and intelligence, digital, estates, quality improvement and financial stewardship.

Our Workforce

The Leeds One Workforce Strategic Board (LOWSB) brings partners together to understand and prioritise the strategic actions required to strengthen and support our health and care workforce. There are seven strategic priorities of the LOWSB, including:

1. Integrated workforce design
2. Growing and Developing registrants
3. Working across organisations
4. Preventing ill health
5. Narrowing inequalities
6. Learning together and improving health and wellbeing.

These priorities will help empower Leeds health and care staff to support the delivery the city's vision.

Within each strategic workforce priority there are a series of collaborative initiatives that together form the Leeds One Workforce programme, coordinated by the Leeds Health and Care Academy.

The approach taken to workforce issues in Leeds enables all partners in the health and care system to drive forward shared strategic workforce priorities in an integrated way, with the ambition of optimising investment and resource, focusing expertise, coordinating activity, and ensuring benefits are realised for the whole health and care system.

Research and Academia

The Leeds Academic Health Partnership (LAHP) is one of the largest and most diverse academic partnerships in the UK. It is a collaboration between three of the city's universities, our local NHS organisations, Leeds City Council, Leeds City College, the regional health and care partnership, the regional economic enterprise partnership, industry and third sector organisations. The LAHP draws on this collection of world-class expertise to discover transformative, sustainable solutions that can help solve some of the city's hardest healthcare challenges.

Communication and Involvement

The Leeds People's Voices Partnership brings engagement and involvement leads from across the partnership together to share their work. Their common aim is 'to improve the way we hear the voices of local people, particularly those living with the greatest health inequalities'.

The aspiration is that insight (collected from people living in Leeds) is used alongside data to give our decision makers the tools they need to really put people's voices at the centre of decision making.

The Strategic Communications Group, and its supporting Operations group, brings together communications professionals from across the partnership. Their aim is to focus communication teams across the city on supporting the key strategic priority areas, to create insight driven behaviour change campaigns and to promote the work of the partnership to internal and external audiences.

Leadership and Culture

A focus for our health and care partnership is to deliver system leadership, culture and change focussed on developing skills and behaviours underpinning integrated care. Working as 'Team Leeds' our leaders have a one city voice with a shared understanding and ownership of unified positions and messages that improves the health and wellbeing of our population. Using a common narrative, we will clearly describe why we work together, what we aim to achieve, and how we will do it together. We will consistently reflect our shared vision and ambition in the plans and individual contributions of all partners.

The Health and Wellbeing Board provides leadership and direction to help influence partners and stakeholders within Leeds to achieve the five Health and Wellbeing Strategy outcomes for all people and communities in the city. The Board also uses its influence to support organisations across sectors and key partnerships to drive personalisation in health and care, transform the use of information and analytics and create a culture of innovation in the city which will improve outcomes for people. Furthermore, helping to build a strong research culture in the city, which empowers our workforce to use evidence to make a difference to tackling health inequalities and improving health and wellbeing outcomes for all ages.

Data and Intelligence

The Office of Data Analytics (ODA) is a citywide partnership between Leeds City Council and the ICB in Leeds, which aims to provide one central source of data and information to all partners, including the city's Population and Care Delivery Boards. The ODA works closely with clinicians and professionals and supports wider training and skills to make use of the data, insight, and information it produces. Leeds benefits from an advanced linked data set, called the Leeds Data Model (LDM),

which is maintained by the ODA. The LDM brings together primary, secondary, and community care data in pseudonymised form to create a picture of the health of the Leeds-registered population. The LDM contains information on population needs and disease prevalence, socio-demographics, service utilisation and (through combining these sets of information), population health inequalities This data is further enhanced by the intelligence and insight we received from communities and people's voices supporting the boards to meet the needs and outcomes for their population. This data and insight is used to enable and improve decision making and support delivery of the city strategies and plans. The insight from the LDM and communities are integral to enabling boards to develop a good understanding of their population.

The Local Care Partnerships, with support from the ODA, are implementing a community-based model to increase digital health participation. As services increase their digital solution offer to improve access and responsiveness for patients this can often negatively impact our most vulnerable communities and we know that people who are digitally excluded are also more likely to be heavier users of face-to-face services. The city's digital health hubs work closely with specific demographics with poorer health outcomes to support our city ambition of improving the health of the poorest the fastest. Increasing digital inclusion and health literacy provides people with the skills and knowledge to access support information and self-management tools to improve their health and wellbeing as well as supporting them in other areas such as education, skills, and employment. This, in turn, reduces the demand for unnecessary appointments and leads to fewer hospital appointments, supporting achievement of our system goals.

In addition, the development of the shared care record in Leeds will further open-up healthcare records, through appropriate access controls, to those who need to see them, including citizens. Our aim is one version and central source of data and information accessible by all partners to enable the identification and reduction of variation, short and long-term planning, continual quality improvement as well as effective operational management. Staff have training and skills to use data, insight, and information as intelligence to drive change; and citizens can access data about themselves and their community to help them take ownership for their health and wellbeing. Through the ODA, we:

- Drive efficiency and build capacity through appropriate use of technology and automation, with the aim of delivering outcome-focussed intelligence.
- Enable data-driven health and care service improvement, demonstrating the positive impact of health and care interventions through appropriate, accessible data visualisation and presentation.
- Work with partners across the city to ensure access to data and insights; and to drive improvement in data literacy, encouraging curiosity and confidence.
- Promote a person-centred approach to intelligence.

- Innovate with leading edge technology and accessible products, with a “cloud first” and “do it once, share many” approach.
- Influence, advise and advocate best practice in use of data and insights.
- Apply robust information governance around our data assets and data sharing protocols and processes to keep our information assets safe and secure.
- Apply transparency by openly publishing central standards, our processes, and methodologies.

Digital

By making better use of data and technology, and by taking a person-centred approach to service design and delivery, we will improve the way we can support people in their daily lives, helping them achieve their ambitions and overcoming any challenges they may face. The Digital Strategy for Leeds has been written to underpin Leeds’ Best City Ambition and describes the key underpinning initiatives that we will put into place to ensure people are not left behind as we move towards our digital-first approach to delivering services. Each of these foundations underpin everything we do and provides the basis of how we intend to use existing and emerging technologies to serve the people of Leeds.

- **Data management, access, and use:** Better collection, management, and use of data that facilitates the delivery of improved, personalised services.
- **Connectivity and infrastructure**: Delivery of 21st century connectivity and infrastructure that provides the backbone for world-class service delivery.
- **Digital inclusion**: Continuing work with people to ensure equal opportunity to develop skills and access digital tools, technology and services that are the right for them.
- **Digital skills:** Lifelong learning that ensures people continually have the right skills to get online, access digital services, and do their job effectively.
- **Digital and data ethics**: Scrutiny and sense checking to ensure that any use of data or introduction of new technology or digital service is sound, and ‘the right thing to do’.

Our Digital Strategy mirrors the ‘life course approach’ to clearly articulate the impact of our plans for digital at every stage of a person’s life from early years to older age – Starting well, living well, working well, and ageing well.

Starting well:

Using modern data technologies and techniques, we will analyse population health and other data to understand what determines a person’s health and life chances from birth through to old age. This will help us to reduce inequalities and design impactful services for the people who need them the most. We will achieve this by:

- using data (disaggregated by deprivation and key demographic variables) to identify and eliminate inequities.
- introducing new ways to stay healthy including education and services; and
- ensuring that all children can access and use technology.

Living and ageing well:

Using new technologies to deliver health and wellness services tailored for individuals and ensure that people's information follows them through their journey regardless of the organisation they are interacting with. We will help people to stay healthy using innovative tools such as wearable monitors, augmented reality apps, or coaching tools. We will achieve this by:

- Ensuring information can be shared between partner organisations, adhering to rigorous information governance policies and procedures.
- Making services easier to find and access.
- Using automation technology to make services better.
- Launching new ways for people to stay healthy using technology.

Working well:

Building on existing collaboration by improving information flow between organisations and supporting the city's inclusive growth ambitions. Our thriving digital community, modern infrastructure and skilled workforce will attract new and established businesses to Leeds. We will achieve this by:

- Investing in infrastructure to support the services we deliver.
- Supporting our vibrant digital economy that creates inclusive growth.
- Taking a #TeamLeeds approach to dealing with cyber threats.
- Building and coordinating an innovation network that is accessible to all.

Estates

Our vision is that Leeds will have a world class health and care estate that has great places to access services and to work, creating and supporting patient and staff wellbeing. Spaces will be flexible and fit for purpose, enabling services to be delivered in the communities here they are needed most, tackling health inequalities, and achieving a healthy population. Our estate is an enabler to support reducing health inequalities, effective system integration, digital transformation, workforce wellbeing, future growth, and service redesign, and importantly achieving our system goals.

Quality Improvement

Quality improvement (QI) is about establishing a culture of continual improvement and theory of change philosophy that is embedded at all levels of the system and can be articulated by leaders at every level and in every profession. Each organisation will continue to use their established ongoing quality improvement methodology. However, where partners come together, we will increasingly adopt a common quality improvement language, core skills, and set of tools. We will create the conditions that enable staff to identify, lead and deliver improvement and change and ensure all staff understand that they have two facets to their role: their core job (doctor, nurse, social worker, administrator etc); and the job to continually improve the quality, efficiency, and effectiveness of the way they deliver work.

A model has been developed to highlight the potential architecture for the QI capability at system level and this is aligned to our organisational objectives. The Leeds Quality Improvement Collaborative has been established and continues to explore opportunities for collaborative QI work and are planning to develop a quality improvement framework during 2023, based around the people, processes and structures required from a system level perspective.

Financial Stewardship

As a partnership we will undertake financial planning in an open and transparent way, ensuring all partners can individually and collectively articulate how the system acts as a steward of all resources to drive the greatest health gain for the population and the financial sustainability of all partners.

7. Summary and Next Steps

Our Healthy Leeds Plan sets out the contribution of the health and care system towards achieving the vision of our Health and Wellbeing Strategy. This work will be driven through our Leeds Health and Care Partnership, which will work to improve outcomes for the people of Leeds, experience of health and care services and the use of the Leeds pound through our two shared system goals and a focus on the 26% of the population who live in the 10% most deprived areas nationally.

These goals are:

1. Reduce preventable unplanned care utilisation across health settings; and
2. Increase early identification and intervention (of both, risk factors and actual physical and mental illness).

To meet these, we will apply an evidence-based, population health approach to drive innovation and deliver person-centred, integrated health and care for the people of Leeds. This will be supported by our city's capabilities – including digital, estates, workforce, quality improvement and research.

Our initial five areas of focus will evolve over time, as the Leeds Health and Care Partnership draws on these capabilities and in doing so develops increasingly sophisticated methods for identifying need and intervening early to prevent poor outcomes. These will be used to identify future priorities, but for now, our next steps over the first few years of this plan are to bring about positive change within the priority areas identified.

The trajectories and plans in the following appendices summarise our ongoing and continued work to improve the effectiveness, efficiency and impact of health and care services in Leeds and summarise the work already in train to ensure Leeds continues to make progress on national requirements and indicators.

Appendices

APPENDIX ONE: Leeds Operational Plan – Anticipated trajectories for National Indicators

This appendix summarises the plan against the 31 national objectives for Leeds. It summarises current performance, anticipated performance by March 2024, the board overseeing the work and interventions that will be made over the next 12 months to support the system in meeting the target.

Urgent and emergency care

1. National Planning Objective

To improve A&E waiting times so that no less than 76% of patients are seen within four hours by March 2024 with further improvements in 2024 / 2025.

Baseline position: 76.5% April 2023

Anticipated position March 2024: 76%

Interventions to support achievement:

- Enhanced Community Response - deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to Emergency Departments (ED) attendance / admissions to hospital.
- Covid Urgent Eyecare Service (CUES).
- Social prescribing in A&E.
- PCAL+ - Creating a new single gateway that brings together the Primary Care Access Line (PCAL) and the Single Point Urgent Referral (SPUR) and Yorkshire Ambulance Service (YAS) push model.
- Enhanced Care at Home - Improving our urgent community offer to support people at home and reduce unplanned admissions.
- Active Recovery at Home - Increasing the number of people who can be supported at home following hospital discharge.
- Rehab and Recovery Beds - optimising and recommissioning intermediate care beds in Leed
- Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time
- Community Ambulatory Paediatric Service (CAPS).

Board overseeing progress: Same Day Response Board and System Flow Steering Group

2. National Planning Objective:

Improve category 2 ambulance response times to an average of 30 minutes across 2023 / 2024, with further improvements in 2024 / 2025.

Baseline position: 34 minutes, March 2023

Interventions to support achievement: Yorkshire Ambulance Service regional transformation work which includes expanding capacity, transforming services and improving efficiencies.

Board overseeing progress: Same Day Response Board

3. National Planning Objective:

Reduce adult general and acute bed occupancy to 92% or below.

Baseline position: 98.1% April 2023

Anticipated position March 2024: 98% (Occupancy of 92% not possible given level of demand, with any further reduction used to support elective recovery).

Interventions to support achievement:

- Out of Hospital Project for those with no fixed abode / multiple complex disadvantages.
- PCAL+ Creating a new single gateway that brings together PCAL and SPUR & Yorkshire Ambulance Service (YAS) push model.
- Community Ambulatory Paediatric Service (CAPS)
- Enhanced Community Response - deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to ED attendance/admissions to hospital.
- Active Recovery at Home - Increasing the number of people who are able to be supported at home following hospital discharge.
- Rehab and Recovery Beds - optimising and recommissioning intermediate care beds in Leeds.
- Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time.

Board overseeing progress: System flow steering group.

Community Health Services

4. National Planning Objective:

Consistently meet or exceed the 70% 2-hour turgent community response standard.

Baseline position: 56% March 2023

Anticipated position March 2024: 70%

Interventions to support achievement:

- Enhanced Community Response
- Enhanced Care at Home - improving our urgent community offer to support people at home and reduce unplanned admissions.

Board overseeing progress: Same day response board and Frailty Board

Primary Care

5. National Planning Objective:

Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Interventions to support achievement:

- Children's system flow.
- Digital remote monitoring for long term conditions and mental health
- Long COVID review and rehabilitation model development.
- Several respiratory initiatives including MART (maintenance and reliver therapies), expansion of pulmonary rehab, spirometry next step.
- COVID urgent eyecare services.
- Advice and guidance.
- Ophthalmology re-procurement.
- Social prescribing.
- Community digital health hubs.
- Integrated weight management.
- Multimorbidity – three or more long term conditions and mental health - delivery of Diabetes Steering Group work.

Board overseeing progress: Primary Care Board

6. National Planning Objective:

Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

Baseline position: 81.4%

Anticipated position March 2024: Anticipated target to be established.

Interventions to support achievement: Enhanced Access Service

Board overseeing progress: Primary Care Board

7. National Planning Objective:

Continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024.

Baseline position: 4,980K March 2023

Anticipated position March 2024: 5,019K

Interventions to support achievement:

- Implementation of the access recovery plan
- Delivery of the primary care workforce action plan

Board overseeing progress: primary care board.

8. National Planning Objective:

Continue to recruit 26,000 Additional Roles Reimbursement Scheme roles by the end March 2024.

Baseline position: 295 whole time equivalent April 2023.

Anticipated position March 2024: 515 whole time equivalent by December.

Interventions to support achievement: deliver of the primary care workforce action plan.

Board overseeing progress: Primary Care Board

9. National Planning Objective:

Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels

To be reported on at a West Yorkshire level.

Elective Care

10. National Planning Objective:

Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties).

Baseline position: 715 March 2023

Anticipated position March 2024: 0

Interventions to support achievement:

- Opthalmology re-procurement
- ENT and Adult hearing Loss re-procurement
- Gastro re-procurement
- Reduction in outpatient follow up
- Advice and guidance
- Waiting well for planned care

Board overseeing progress: Planned Care Board

11. National Planning Objective:

Elective activity levels as a proportion of 2019 / 2020 activity reaching 108%.

Baseline position: N/A

Anticipated position March 2024: 106.5%

Interventions to support achievement:

- Patient Initiated follow up.
- ENT and adult hearing loss re-procurement.
- Reduction in outpatient follow up.

Board overseeing progress: Planned Care Board

Cancer

12. National Planning Objective:

Continue to reduce the number of patients waiting over 62 days.

Baseline position: 329, February 2023

Anticipated position March 2024: 288 people

Interventions to support achievement:

- Two weeks wait frailty assessment clinics
- Optimal pathways: head and neck, gynaecology, prostate, bladder, lung, skin, colorectal, Upper GI, pancreas.
- MDT streamlining

Board overseeing progress: Cancer Board

13. National Planning Objective:

Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

Baseline position: 75.5%

Anticipated position March 2024: 75%

Interventions to support achievement:

- Implement faecal immunochemical test.
- Two weeks wait frailty assessment clinics.
- Open access chest x-rays.
- Practice nurse training enable to request chest x-rays.
- Brain and central nervous pathway – developing a straight to test pathway.
- Teledermatology.
- Optimal pathways: head and neck, gynae, prostrate, bladder, lung, skin, colorectal, Upper GI, pancreas.

Board overseeing progress: Cancer Board

14. National Planning Objective:

Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

Interventions to support achievement:

- Pinpoint blood test.
- Teledermatology.
- Implementation of breast pain clinic.
- Implement faecal immunochemical test.
- Open access chest x-rays.
- Practice nurse training.
- Brain and central nervous pathway developing a straight to test pathway, lung screening.

Board overseeing progress: Cancer Board

Diagnostics

15. National Planning Objective:

Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

Baseline position: 90.4%

Anticipated position March 2024: 95%

Interventions to support achievement:

- Community Diagnostic Centres in Seacroft Hospital, Armley and Beeston Medical centres.
- LTHT Transformation programme – Diagnostics.
- Gastro re-procurement.
-

Board overseeing progress: Planned Care Board

16. National Planning Objective:

Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

Baseline position: No specific target.

Anticipated position March 2024: No specific target.

Interventions to support achievement:

- Community diagnostic centres in Seacroft Hospital, Armley and Beeston Medical Centres.
- LTHT Transformation Program - Diagnostics

Board overseeing progress: Planned Care Board

Maternity

17. National Planning Objective:

Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.

Baseline position: still birth rate 3.9 per 1000 births February 2023

Anticipated position March 2024:

- still birth rate less than 3.5 per 1000 births
- neonatal mortality less than or equal to 3.55 per 1000 births
- maternal mortality 0
- serious intrapartum brain injury less than or equal to 10 per annum

Interventions to support achievement:

Single delivery plan includes:

- MNVP (Maternity and Neonatal Voices Partnership) Deep dive into engagement with service users to ensure care is accessible and close to home.
- Gestational Diabetes – targeted healthy eating and physical activity interventions.
- Doulas.
- Maternity Mental Health.

Board overseeing progress: Maternity Board

18. National Planning Objective:

Increase fill rates against funded establishment for maternity staff.

Baseline position: quarter 3 2022 data:

- Midwifery workforce 342.21 whole time equivalent

- Obstetric workforce 87.82 whole time equivalent
- Neonatal nurses 128.32 whole time equivalent
- Neonatal consultants 11.5 whole time equivalents
- Aesthetic workforce 9 session per week

Anticipated position March 2024:

- Midwifery workforce 363.36 whole time equivalent
- Obstetric workforce 91.62 whole time equivalent
- Neonatal consultants 13 whole time equivalent
- Aesthetic workforce 12 sessions per week

Interventions to support achievement: As a system we are focussed on implementing the recommendations through the single delivery plan including the workforce element.

Board overseeing progress: Maternity Board

Use of resources

19. National planning objective:

Deliver a balanced net system financial position for 2023 / 2024.

Description of plan can be found in the main Healthy Leeds Plan (HLP).

Workforce

20. National planning objective:

Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise.

Description of plan can be found in the main HLP – coordinated by Strategic One Workforce Board.

Mental Health

21. National Planning Objective:

Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019).

Baseline position: 8990 rolling 12 months

Anticipated position March 2024: 8800 rolling 12 months

Interventions to support achievement:

- Compassionate Leeds - identifies areas where our current systems are failing to provide the intervention and support that children and families need which align to the themes of improvement identified through the national Early Help Review.
- Prevention / timely access to services

Board overseeing progress: Children and Young Peoples Board

22. National Planning Objective:

Increase the number of adults and older adults accessing Improving Access to Psychological Therapies (IAPT) treatment.

Baseline position: 7212 quarter 4 2022/2023

Anticipated position March 2024: 7202

Interventions to support achievement: working to reduce waiting times to access NHS Talking Therapies

Board overseeing progress: Severe Mental Illness Board

23. National Planning Objective:

Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.

Baseline position: 10,275 February 2023

Anticipated position March 2024: 11,693

Interventions to support achievement:

- Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships and PCNs.
- Community Mental Health Transformation - Developing and increasing capacity in psychological therapies for people with SMI and more complex needs.

- Community Mental Health Transformation – Developing and testing new workforce roles.
- Early intervention in psychosis pathway - Further develop EIP to incorporate identification and intervention for those with at-risk mental states.

Board overseeing progress: Severe Mental Illness Board

24. National Planning Objective:

Work towards eliminating inappropriate adult acute out of area placements.

Baseline position: 663 bed days quarter 2 2022 / 2023

Anticipated position March 2024: 450 bed days

Interventions to support achievement:

- Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships and PCNs.
- Community Mental Health Transformation - Developing and increasing capacity in psychological therapies for people with SMI and more complex needs.
- Community Mental Health Transformation – Developing and testing new workforce roles.
- Review and evaluation of MH crisis provision and models of crisis alternatives & crisis pathway redesign.
- Review and evaluation of mental health crisis provision and models of crisis alternatives and crisis pathway redesign

Board overseeing progress: Severe Mental Illness Board

25. National Planning Objective:

Recover the dementia diagnosis rate to 66.7%

Baseline position: 68.7% March 2023

Anticipated position March 2024: 68.5%

Interventions to support achievement:

- Practices to review their dementia prevalence rate and identify patients at clinical risk of dementia, offering assessment and referral.

Board overseeing progress: Severe Mental Illness Board and Frailty Board

26. National Planning Objective:

Improve access to perinatal mental health services.

Baseline position: 770 March 2023

Anticipated position March 2024: 863

Interventions to support achievement: Maternity Mental Health Service

Board overseeing progress: Maternity Board and Serious Mental Illness Board

People with a learning disability and autistic people

27. National Planning Objective:

Ensure 75% of people aged over 14 years on the GP learning disability registers receive an annual health check and health action plan by March 2024.

Baseline position: 83%, March 2023

Anticipated position March 2024: 75%

Interventions to support achievement: Annual health checks for people with learning disability. Focus on those patients who have not received an annual health check in previous 18 months.

Board overseeing progress: Primary Care Board

28. National Planning Objective:

Reduce reliance on inpatient care while improving the quality of inpatient care so that by March 2024 no more than 30 adults with a learning disability and / or who are autistic per million adults and no more than 12 -15 under 18s with a learning disability and / or who are autistic per million under 18s are cared for in an inpatient unit.

Baseline position: 31 across ICB and NHSE commissioned beds quarter 3 2022 / 2023.

Anticipated position March 2024: 26 (15 commissioned by the ICB and 11 NHSE / provider collaborative

Interventions to support achievement: No new initiatives planned for the next 12 months although an initiative focused on LD / autism step-up crisis alternative is in the process of being scoped.

Board overseeing progress: Learning Disability and Neurodiversity Population Board

Prevention and health inequalities

29. National Planning Objective:

Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024

Baseline position: 65.9% quarter 4 2022 / 2023

Anticipated position March 2024: 77%

Interventions to support achievement: Multimorbidity three long-term conditions and a serious mental illness.

Board overseeing progress: Long-Term Conditions Board

30. National Planning Objective:

Increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20 percent on lipid lowering therapies to 60%.

Baseline position: 63.9%, quarter 4 2022 / 2023

Anticipated position March 2024: 60%

Interventions to support achievement:

- InHIP project delivery – WY / AHSN funded Health Inequalities project.
- STF project Lipids - Project delivery on behalf of WY and Leeds.

Board overseeing progress: Long-Term Conditions Board

31. National Planning Objective:

Continue to address health inequalities and deliver on the Core20PLUS5 approach.

Baseline position: Current performance not available.

Anticipated position March 2024: No specific target yet.

Interventions to support achievement:

- Waiting well for planned care
- LCP community grants, social prescribing, Community of practice, digital health hubs
- Social prescribing in A&E, home plus, unplanned care for healthy adults
- Compassionate Leeds
- Prevention / timely access to services for children and young people
- Out of Hospital Project for those with no fixed abode
- Women's health programme

APPENDIX TWO: Leeds Operational Plan Implementation

The following pages describe initiatives that our Population and Care Delivery boards will be oversee implementation of or continued implementation of over the next year to impact our partnership goals, the West Yorkshire 10 big ambitions or NHS national objectives.

Cancer Population Board

CAN1 – Earlier Diagnosis – Implement FIT

Agreeing and implementing pathway change to incorporate earlier Diagnosis Implement Faecal Immunochemical Testing within lower GI two week wait pathway.

Population Outcome link: People with cancer living in Leeds with be diagnosed earlier where evidence shows this to be beneficial.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: Meet the cancer faster diagnosis by March 2024 and increase the percentage of cancers diagnosed at stages 1 and 2

Start date: July 2023

CAN2 – Earlier Diagnosis - Pinpoint

Evaluation of the Pinpoint blood test which aims to use biomarkers, patient history and demographics to create a cancer risk score for patients attending primary care with symptoms.

Population Outcome link: People with cancer living in Leeds with be diagnosed earlier where evidence shows this to be beneficial.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer

Impact on NHS national objective: increase the percentage of cancers diagnosed at stages 1 and 2.

Start date: April 2022

CAN 3 – Earlier Diagnosis - Teledermatology

Rollout of new cameras for teledermatology in primary care. Work is ongoing to identify funding to also replace dermatascopes and to create a larger pool of camera stock.

Population Outcome link: People with cancer living in Leeds with be diagnosed earlier where evidence shows this to be beneficial.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: Meet the cancer faster diagnosis by March 2024 and increase the percentage of cancers diagnosed at stages 1 and 2.

Start date: June 2023

CAN4 – Earlier Diagnosis – Open Access Chest X-Ray

Restarting of the open access chest x-ray service for patients with concerns around lung cancer symptoms. The re-launch will be accompanied by a publicity campaign to ensure that as many people as possible can benefit from the service.

Population Outcome link: People with cancer living in Leeds with be diagnosed earlier where evidence shows this to be beneficial.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: Meet the cancer faster diagnosis by March 2024 and increase the percentage of cancers diagnosed at stages 1 and 2.

Start date: September 2023

CAN5 – Earlier Diagnosis – Practice Nurse Training enable to request chest x-rays

Training to enable practice nurses to access ICE and request chest x-rays for patients for whom they have a concern of lung cancer. This will cut down on the need for GPs to make these referrals and for patients to reattend following a nurse appointment.

Population Outcome link: People with cancer living in Leeds with be diagnosed earlier where evidence shows this to be beneficial.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: Meet the cancer faster diagnosis by March 2024 and increase the percentage of cancers diagnosed at stages 1 and 2.

Start date: April 2023

CAN6 – Earlier Diagnosis – Brain and central nervous pathway

Work to develop a straight to test pathway for brain two week wait referrals.

Population Outcome link: People with cancer living in Leeds with be diagnosed earlier where evidence shows this to be beneficial.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: Meet the cancer faster diagnosis by March 2024 and increase the percentage of cancers diagnosed at stages 1 and 2.

Start date: June 2023

CAN7 – Screening and Prevention – Primary Care Screening Champions

Funding to pay for protected time for individuals in the 45 most deprived practices in Leeds to put in place programmes to encourage increased uptake of cervical and bowel screening amongst their patient populations.

Population Outcome link: People living with cancer will receive person centred care.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Start date: April 2023

CAN8 – Person Centred Care – Breast Pain Clinic

Implementation of a specific breast pain clinic to ensure that patients who are suffering from breast pain but who otherwise do not meet the two week wait (2ww) criteria for referral are able to access advice, support, and treatment as necessary.

Population Outcome link: People living with cancer will receive person centred care.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: Increase the percentage of cancers diagnosed at stages 1 and 2.

Start date: October 2022

CAN9 – Person Centred Care – Pre-hab

Launch of a service funded by Macmillan to ensure that patients undergoing cancer treatment are physically prepared and fit enough to withstand the treatment that they are due to undergo and that patients maintain a healthy lifestyle after treatment. This will help to ensure that as many treatments as possible are successful.

Population Outcome link: People living with cancer will receive person centred care.

System goal link: N/A

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: N/A

Start date: June 2023

CAN10 – Person centred care – Two week wait frailty assessment clinics

Developing frailty clinics to assess frail patients who have been referred on the 2ww pathway (starting with Lower GI) to ensure that they are fit for investigations, that they are aware of what pathways entail and that they want to continue with diagnosis and treatment.

Population Outcome link: People living with cancer will receive person centred care.

System Goal link: Goal 1 reduce to preventable unplanned utilisation across health settings.

Impact on NHS national objective: Meet the cancer faster diagnosis standard by March 2024 and continue to reduce the number of patients waiting over 62 days.

Start date: October 2022

CAN11 – LTHT Transformation Programmes

A range of programmes being led within LTHT by the corporate Cancer Team, including:

- Lung screening
- MDT streamlining
- Cardio-Oncology
- Pelvic Exenteration
- patient education programmes
- end of treatments summaries
- health needs assessments / cancer care reviews

Optimal Pathways:

- Head and neck
- Gynaecology
- Prostate
- Bladder
- Lung
- Skin
- Colorectal
- Upper GI
- Pancreas

Population Outcome link: People will receive the safest and most effective cancer treatments that are available.

West Yorkshire 10 Big Ambition link: Earlier diagnosis rates for cancer.

Impact on NHS national objective: Meet the cancer faster diagnosis standard by March 2024, continue to reduce the number of patients waiting over 62 days and increase the percentage of cancer diagnosed at stages 1 and 2.

Start date: Across 2023

Children and Young People Population Board

CYP1 – Keeping Children Safe from Harm – Compassionate Leeds

The Compassionate Leeds case identifies areas where our current systems are failing to provide the intervention and support that children and families need which align to the themes of improvement identified through the national Early Help Review. The case develops our response to supporting our most vulnerable cohorts of children and young people with the ultimate aim of addressing the impact of trauma and adverse life experiences. There are seven discreet projects that sit within the case:

1. Integrated Trauma Resource Team.
2. Futures.
3. Community mental health offer.
4. Child and Family hubs.
5. Cluster based neurodevelopmental support.
6. Neurodevelopment assessment and training for children looked after.
7. Therapy for adolescents on the edge of care.

Population Outcome link: Children are safe from harm.

System Goal link: Goal 2 increase early dentification and intervention.

West Yorkshire 10 Big Ambition link: We will increase the years of life that people live in good health and halt the trend in childhood obesity.

Impact on NHS national objective: Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services and continue to address health inequalities and deliver on the Core20PLUS5 approach.

Start date: June 2023

CYP2 – Children's System Flow

Aim to deliver better system flow for children, which creates a proactive and reactive model of population health management, in which children are seen earlier, and in the most appropriate location. The case describes an approach to system flow in two parts:

1.Children's Care in the Community

1a. Child and Family Community Hubs

1b. Children's Ambulatory Paediatric Service (CAPS)

2.Optimisation of the Children's Assessment and Treatment (CAT) Unit

2a. Healthier at Home

2b. Community IV antibiotics service

2c. Other virtual wards

This is all underpinned by an expansion of the CAT workforce which also enables better optimisation of the CAT rota.

Population Outcome link: Children in Leeds are healthy.

System Goal link: Goal 1 to reduce preventable unplanned care utilisation.

West Yorkshire 10 Big Ambition link: We will increase the years of life that people live in good health.

Impact on NHS national objective: Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: April 2023

CYP3 – Children's Mental Health Prevention (Children are happy and have fun) – Prevention / timely access to services

Several projects are included within this workstream to ensure children and young people receive timely access to community based mental health services these also involve a number of thematic reviews to ensure best value.

These include:

- Roll out of the Mental Health Support Teams.
- Review of our third sector SEMH offer (The Market Place and Leeds Mind (THRU).
- Review of our locality-based support offer (including MindMate Wellbeing cluster support).
- Review of the digital support offer.

Population Outcome link: Children are happy and have fun.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: We will increase the years of life that people live in good health.

Impact on NHS national objective: Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services and continue to address health inequalities and deliver on the Core20PLUS5 approach.

Start date: From 2020 – 2023 (multiple projects)

End of Life Population Board

EoL1 – Advanced Care Planning (ACP)

Launch new public Advanced Care Planning guide with Public Health and full review of system wide advanced care planning training. Which includes:

- Launch of new public advanced care planning guide – “what if things change”.
- Full review of system wide advanced care planning training

Population Outcome link: People are approaching the end of their life and are recognised and supported on time. All people approaching the end of life receive high quality, well-co-ordinated care at the right time and with the right people.

System Goal link: Goal 2 increase early identification and intervention.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: April 2023

EoL2 – Early Identification – TIMELY recognition Tool project

Progress trial in Systm1 practices. Engagement with practices regarding outcomes of trial, and its use in supporting early recognition of people nearing the end of their life. Academic validation.

Population Outcome link: People approaching the end of their life are recognised and supported on time.

System Goal link: Goal 2 Increase Early identification and intervention.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: January 2024

EoL3 – Education Programme

Clinical educator funded for 12 months by the Leeds Palliative Care Network to train 2,000 clinical support workers.

Population Outcome link: All people approaching the end of life receive high quality, well-co-ordinated care at the right time and with the right people.

People approaching the end of life and their carers can talk about death with those close to them and in their communities. They feel their loved ones are well supported during and after their care.

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: June 2023

Frailty Population Board

FR1 – Proactive care - National Anticipatory Care Framework (now Proactive Care Framework)

National Framework - Proactive Care Framework: provision of proactive, personalised health & care for people with multiple long-term conditions

Population Outcome link: Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer.

Reducing avoidable disruption to people's lives as a result of contact with services.

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: October – December 2023

FR2 – Proactive Care – Restore 2 and Stumble Training

Training for care home staff in soft signs of deterioration and falls management.

Population Outcome link: Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer.

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: April 2023

FR3 – Proactive Care – Frailty Training

In year funding - frailty training days led by community geriatrician for health and social care staff plus bespoke training for care home staff.

Population Outcome link: Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer.

System Goal link: Goal 2 Increase Early identification and intervention

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: April 2023

Home First Programme – Frailty Board

HF1 - Enhanced Care at Home - Improving our urgent community offer to support people at home and reduce unplanned admissions

- Home Ward (virtual ward).
- Remote Health Monitoring.
- Quick Response (urgent and crisis response 2 hours).
- Emergency cover for carers.
- Rapid response to falls.
- Home Comfort.

Also includes early intervention – how we reduce avoidable admissions and attendances at hospital.

Population Outcome link: N/A

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Consistently meet or exceed the 70% two-hour urgent community response standard.

Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024 / 2025.

Start date: May 2023

HF2 - Active Recovery at Home - Increasing the number of people who are able to be supported at home following hospital discharge

Combining the current Reablement and National Housing Trust (NHT) services Expanding the offer of these combined services to support more people at home.

Population Outcome link: N/A

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

Impact on NHS national objective: Reduce adult general and acute bed occupancy to 92% or below.

Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024 / 2025.

Start date: May 2023

HF3 – Rehab and Recovery Beds – optimising and recommissioning intermediate care beds in Leeds

- Reducing our reliance on spot purchased beds.
- optimising the current community care beds to reduce length of stay.
- designing the model for and recommissioning the rehab and recovery beds in Leeds to a reduced number.

Population Outcome link: N/A

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

Impact on NHS national objective: Reduce adult general and acute bed occupancy to 92% or below.

Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024 / 2025

Start date: May 2023

HF4 - Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time

Population Outcome link: N/A

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

Impact on NHS national objective: Reduce adult general and acute bed occupancy to 92% or below.

Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024 / 2025.

Start date: May 2023

Healthy Adults Population Board

HA1 – System flow health inclusion – Out of hospital project for those with no fixed abode / multiple complex disadvantages

This workstream has several parts:

- Defined service specification for matrix transfer of care teams for vulnerable adults.
- Development work on scaling up nine temporary housing unit beds as part of current out of hour project.
- Emerging work on those on prison release pathways who end up accessing mental health inpatient services (via LYPFT) shortly after release.

Population Outcome link: People in Leeds live well, and a standard of living which supports their health and wellbeing.

System Goal link: Goal 1 Reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: Increase the years of life that people live in good health.

Impact on NHS national objective:

- Reduce general and acute bed occupancy to 92% or below.
- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

Start date: July 2023

HA2 - Women's Health

A life course approach to women's health reduces pressures on waiting lists (gynaecology some of the longest waiters and second most used service in planned care) and increases overall health of women.

Focus on pelvic floor health, endometriosis and menopause pathways also link to mental health of women.

Population Outcome link: People in Leeds will be physically healthy.

System Goal link: Goal 2 - increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: Increase the years of life that people live in good health.

Impact on NHS national objective:

- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.
- Continue to address health inequalities and deliver on the Core20PLUS5 approach.

Start date: to be confirmed.

HA3 - Community Strengths

- Community Grants Scheme: eight LCPs funded to define, develop and implement hyper local health and wellbeing intervention.
- Social Prescribing: Proactive person-centred approach to working with people in their communities to address nonclinical health and wellbeing needs, and to connect with services to address wider determinants of health.

- Working hyperlocal to develop and pilot a social prescribing community of practice that bring together disparate parts of the system under a shared purpose.
- Community hubs delivering support in and with communities experiencing the greatest health inequalities to enable connection with health and care services using digital means.

Population Outcome link: People in Leeds will be mentally and physically healthier for longer and where needed, supported to live well.

System Goal link: Goal 1 reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: Increase the years of life that people live in good health.

Impact on NHS national objective:

- Continue to address health inequalities and deliver on the Core20PLUS5 approach.
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: March 2023

HA4 - System Flow Healthy Adults - Social Prescribing (SP) in A&E; home plus; unplanned care for healthy adults

Pilot project with SP embedded in A&E working with repeat high intensity users of the service.

- Home Plus: the Home Independence and Warmth Service (branded as Home Plus (Leeds)) is aimed at enabling and maintaining independent living through improving health at home. It does this through addressing:
    - risk of falling
    - energy efficiency and affordability
    - warmth and condensation / damp
    - hazards relating to electrics, plumbing and gas that require repairs.
- Data driven approach to understand unplanned care usage by the Healthy Adults segment. Data cut by method of attendance, conveyancing rates, admission conditions, non-admission conditions. All to be cut by:
    - Age
    - Gender
    - Ethnicity
    - Indices of multiple deprivation (IMD) / Primary Care Network (PCN).

Population Outcome link: People in Leeds will be mentally and physically healthier for longer and where needed, supported to live well.

System Goal link: Goal 1 reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: Increase the years of life that people live in good health.

Impact on NHS national objective:

- Continue to address health inequalities and deliver on the Core20PLUS5 approach.
- Improve A&E waiting times so that no less than 76% patients are seen within four hours by March 2024.

Start date: March 2023

Long Term Conditions Population Board

LTC1 - Multimorbidity (3 long-term conditions (LTC) plus mental health)

Digital remote monitoring implementation for 3 plus long-term conditions and mental health.

Population Outcome link: People with a long-term condition take an active role in managing and improving their condition and the prevention of future multi-morbidities.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: September 2023

LTC2 – Multimorbidity (3 long-term conditions (LTC) plus mental health) Long Covid review and rehabilitation model development

Population Outcome link: N/A

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: In development.

LTC3 - Multimorbidity (3 long-term conditions (LTC) plus mental health) – delivery of respiratory steering group work

- MART – implementation of AZ work with target three Primary Care Networks.
- Expansion of pulmonary rehab.
- Spirometry next steps.

Population Outcome link: I'm as healthy as I can be with my long-term condition.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: January 2023

LTC4 – Multimorbidity (3 long-term conditions (LTC) plus mental health) – delivery of diabetes steering group work

- Conclude local diabetes remission pilot (learnings blend with integrated weight management model).
- Facilitation of NHS diabetes Prevention Programme
- Referrals treatment and care implementation
- Continuous glucose monitoring implementation.

Population Outcome link: I'm as healthy as I can be with my long-term condition.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: January 2022

LTC5 – Multimorbidity (3 long-term conditions (LTC) plus mental health) – delivery of cardiovascular (CVD) steering group work

- Coordination of hypertension and lipids work.
- Heart failure work exit
- Anticoagulation next steps

Population Outcome link: I'm as healthy as I can be with my long-term condition.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024.

Start date: January 2022

LTC6 - Multimorbidity (3 long-term conditions (LTC) plus mental health) – delivery of neurology steering group work

- CNRS Phase 1 implementation and phase 2 business case development
- FND pathway mapping and next steps

Population Outcome link: I'm as healthy as I can be with my long-term condition.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: October 2022

LTC7 - Lipids – innovation for healthcare inequalities project delivery

West Yorkshire / Academic Health Science Network funded Health Inequalities project

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%.

Start date: July 2023

LTC8 - Lipids – System transformation fund project Lipids

Project delivery on behalf of West Yorkshire and Leeds.

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%.

Start date: July 2023

LTC9 - Home Oxygen – delivery of home oxygen contract across Yorkshire and Humber

Delivery of home oxygen contract across West Yorkshire (WY) plus implementation of WY Quality, Innovation, Productivity and Prevention (QIPP) with VAT legal change granted.

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20% on lipid lowering therapies to 60%.

Start date: July 2023

LTC10 - Integrated Weight Management

Options appraisal if Integrated Weight Management is not supported.

Population Outcome link: People with a Long-term condition take an active role in managing and improving their condition and the prevention of future multi-morbidities.

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: July 2023

Maternity Population Board

M1 - Maternity and Neonatal Voices Partnership

- Deep dive into engagement with service users to ensure care is accessible and close to home.
- Work with LTHT on staff satisfaction survey's / staff feedback.

Population Outcome link:

- People receive personalised maternity care.
- People receive the support they need to improve or maintain their emotional wellbeing.
- Safe and effective high-quality maternity care is accessible for everyone.
- People are prepared for parenthood.

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries, and a reduction in maternal morbidity and mortality by 2025.

Impact on NHS national objective: Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.

Start date: May 2023

M2 - Gestational Diabetes

Provide targeted healthy eating and physical activity interventions, infant feeding support, future pregnancy planning education and deliver community-based group peer support sessions to manage diabetes and unhealthy maternal weight.

Population Outcome link:

- People receive personalised maternity care.
- People receive the support they need to improve or maintain their emotional wellbeing.
- Safe and effective high-quality maternity care is accessible for everyone.
- People are prepared for parenthood.

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025.

Impact on NHS national objective: Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.

Start date: May 2023

M3 - Doulas

Health inequalities non-recurrent funding was used to mobilise the Leeds Doula service. This would require further funding from September 2023 (identified in the health inequalities in community pre-value proposition). The maternity population board, through their logic models, have identified this as a key priority to ensure "people received personalised maternity care safely"

Population Outcome link: Families and babies are supported to achieve optimum physical health.

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025.

Impact on NHS national objective: Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.

Start date: July 2023

M4 - Maternity Mental health (for West Yorkshire)

The aim of MMHS is to fill the gap not already met by other services and provide support to women experiencing moderate to severe or complex mental health difficulties, including trauma relating to their birth experience, fear of birth itself (tokophobia), and trauma relating to pregnancy and baby loss (including loss through removal into social care).

Population Outcome link:

- People receive personalised maternity care.
- People receive the support they need to improve or maintain their emotional wellbeing.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025.

Impact on NHS national objective:

- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury.
- Improve access to perinatal mental health services.

Start date: May 2023

Mental Health Population Board

MH1 - Community Health Transformation – mobilisation of new integrated model of care for community mental health with local care partnerships and primary care networks

Piloting and testing of newly designed multiagency integrated MH hub model in three local care partnership areas (4 PCNs) ahead of phased roll out across all LCP / PCNs in Leeds.

Population Outcome link: People's quality of life will be improved by timely access to appropriate mental health information, support, and services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective:

- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
- Work towards eliminating inappropriate adult acute out of area placements.

Start date: July 2023

MH2 - Community Mental Health transformation – Psychological therapies

Developing and increasing capacity in psychological therapies for people with SMI and more complex needs.

Population Outcome link: People's quality of life will be improved by timely access to appropriate mental health information, support, and services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective:

- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
- Work towards eliminating inappropriate adult acute out of area placements.

Start date: April 2023

MH3 - Community Mental Health Transformation – Developing and testing new workforce roles

Including within primary care (including Additional Roles Reimbursement Scheme roles) and in the third sector.

Population Outcome link: People's quality of life will be improved by timely access to appropriate mental health information, support, and services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective:

- Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services.
- Work towards eliminating inappropriate adult acute out of area placements.

Start date: Commenced 2022 / 2023 and progressing to full delivery within new model of care from Q2 2023 / 2024.

MH4 - Improving access to psychological therapy

Working to reduce waiting times to access NHS talking therapies.

Population Outcome link: People's quality of life will be improved by timely access to appropriate mental health information, support and services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective: Increase the number of adults and older adults accessing IAPT treatment.

Start date: 2022 / 2023, in progress

MH5 - Mental Health Crisis - review and evaluation of mental health crisis provision and models of crisis alternatives

Undertaking a deep dive analysis of value and outcomes being delivered in our crisis services pathway, to help inform how we can, reduce the inequalities in access, and improve the experience and outcomes for people accessing support, making the best use of available resources.

Population Outcome link: People's quality of life will be improved by timely access to appropriate mental health information, support, and services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective: Work towards eliminating inappropriate adult acute out of area placements.

Start date: June 2023

MH6 Community Health Transformation – physical health severe mental illness

Further develop outreach and pathways improve access to physical health checks and interventions for people with SMI.

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective: N/A

Start date: Q4 2022 / 2023 testing outreach models in early implementer sites for new model of care.

MH7 - Community Health Transformation – Early intervention in psychosis pathway

Further develop Early Intervention in Psychosis (EIP) to incorporate identification and intervention for those with at-risk mental states.

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective: Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health service.

Start date: April 2023 (investment for ARRS pathway in Q3 2022 / 2023 recruitment-recurrent investment for delivery from 1 April 2023).

MH8 - Mental health crisis - street triage

Implementation and evaluation of new delivery model for Street Triage.

Population Outcome link: N/A

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: Reduce the gap in life expectancy for people with mental health conditions.

Impact on NHS national objective: Work towards eliminating inappropriate adult acute out of area placements.

Start date: Redesigned model implementation commenced April 2023

Planned Care Delivery Board

PC1 - Early Diagnosis – Community Diagnostic Centres (CDCs)

Business case approved to develop three sites as part of the CDC model for Leeds, this will expand diagnostic capacity at Seacroft Hospital, Armley and Beeston medical centres for a range of diagnostic tests, including CT, MRI, plain film x-ray, ultrasound, phlebotomy.

Population Outcome link: Planned care services are accessible to all regardless of who they are.

System Goal link: Goal 2 Increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

Start date: Implementation underway across all three sites, to be delivering additional diagnostic activity by Q2 2023 / 2024. A business Case for 2023 /2024 and 2024 / 2025 submission due June 2023.

PC2 - Earlier Diagnosis – Leeds Teaching Hospital NHS Trust transformation Programme Diagnostics

Multiple projects:

- Delivery of 6 week wait recovery.
- Responsible requesting.
- Opening new Pathology Estate.
- Community Diagnostic Centres.
- Launch Pathology Lab Information System.

Population Outcome link: N/A

System Goal link: Goal 2 Increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Increase the percentage of patients that receive a diagnostic test within six weeks, in line with the March 2025 ambition of 95%.
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

Start date: In progress.

PC3 - Managing Capacity and Elective Recovery – Covid urgent eyecare services (CUES)

Service established August 2020 during COVID-19 pandemic, mandated request by NHS England as routine eye screening had ceased. The service is delivered by Primary Eyecare Services Ltd, the lead for the network of 35 optical practices. Month

on month increasing demand for service and evaluation evidencing impact on primary care and A&E services (to a lesser degree).

Population Outcome link: N/A

System Goal link: Goal 1 Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024 / 2025.

Start date: Service is already established however due to rising demand for service, review of usage and funding model to be undertaken to sustain the service longer term.

PC4 - Managing Capacity and Elective Recovery – Ear, nose and throat and adult hearing loss re-procurement

- Procurement of community services - new contract to be in place April 2024
- Potential Quality, Innovation, Productivity and Prevention (QIPP) opportunities to be identified - longer term savings in bulk buying of hearing aids / reduction in costs of replacement batteries as rechargeable etc.

Population Outcome link: Planned care services are accessible to all regardless of who they are

System Goal link: Goal 2 Increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialities).
- Elective activity levels as a proportion of 19/20 activity reaching 108%.

Start date: April 2024

PC5 - Managing Capacity and Elective Recovery – Gastro re-procurement

- Procurement of community services - new contract to be in place July 2024.
- Potential Quality, Innovation, Productivity and Prevention (QIPP) opportunities to be identified in current contract and for new services.

Population Outcome link:

- Planned care services are accessible to all regardless of who they are.
- People are supported whilst waiting for planned care services.

System Goal link: Goal 2 Increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialities).
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.

Start date: July 2024

PC6 - Managing Capacity and Elective Recovery – Harmonisation commissioning policies

Contribution to ensuring commissioning policies and access to treatments is consistent and equitable across the Integrated Care Board (cuts across population and care delivery boards).

Population Outcome link: N/A

System Goal link: N/A

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: September 2023

PC7 - Managing Capacity and Elective Recovery – Leeds Teaching Hospital NHS Trust transformation programme – planned care

Multiple projects:

- Theatre Productivity
- Day Case
- Patient optimisation
- Reducing non-elective pressures
- BADS

Population Outcome link: N/A

System Goal link: N/A

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: in progress.

PC8 - Managing Capacity and Elective Recovery – Opthalmology re-procurement

- Re-procurement of community-based ophthalmology services – Any Qualified Provider (AQP) window to be reopened to extend current contracts for 1 year until 30/09/24.
- Review of services to identify Quality, Innovation, Productivity and Prevention (QIPP) opportunities – Single Point of Access Cataracts (in line with regional approach) - priorities TBC

Population Outcome link:

- People are supported whilst waiting for planned care services.
- Planned care services are accessible to all regardless of who they are.

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness).

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialities)
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.

Start date: October 2024

PC9 - Outpatient Redesign – Increased use of Patient initiated follow up (PIFU)

Converting appropriate patients from routine planned follow up, to follow up initiated by the patient as clinically indicated.

Population Outcome link: people are supported whilst waiting for planned care services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Elective activity levels as a proportion of 2019 / 2020 activity reaching 108%.

Start date: In progress.

PC10 - Outpatient Redesign – Advice and Guidance

Encouraging clinicians to seek advice and guidance on management and treatment of their patients from an appropriate specialist, so that their condition can be appropriately and safely managed without the need for OP referral.

Population Outcome link: people are supported whilst waiting for planned care services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialities).

Start date: In progress.

PC11 - Outpatient Redesign – reduction in outpatient follow up (OPFU)

Supporting LTHT project team in developing and delivering phased reduction in OPFU activity by 25% (compared to 2019 / 2020 activity), through programme of

Clinical Service Unit targeted benchmarking, identification of opportunities, and implementation.

Population Outcome link: people are supported whilst waiting for planned care services.

System Goal link: N/A

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialities).
- Elective activity levels as a proportion of 2019 / 2020 activity reaching 108%.

Start date: February 2023

PC12 - Outpatient Redesign – Leeds Teaching Hospital NHS Trust Transformation Programme – outpatients

Multiple projects:

- Pathway optimisation, inc. reducing DNA / Canx, clinic utilisation, video / telephone consults, patient hub, estate optimisation.
- OP Quality and improvement, inc. standardisation of process, Robotic Process Automation (RPA), enhanced patient information and patient interface.

Population Outcome link: N/A

System Goal link: N/A

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: February 2023

PC13 - Waiting support – waiting well for planned care

Funding for 1 x Care Navigator / Support worker (HI Funding) start date 2 May 2023.

This scheme will target the most deprived people on elective surgical waiting lists to support them to wait well and to reduce the number of acute attendances whilst waiting for care. Four Primary Care Network areas where we are seeing the highest

numbers of people presenting at A&E whilst they are on planned care waiting list – these are:

- York Road
- Cross Gates
- Middleton and Hunslet
- Burmantofts, Harehills and Richmond Hill

Population Outcome link:

- People are supported whilst waiting for planned care services.
- People agree appropriate and realistic shared health goals and actively participate in their achievement.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Continue to address health inequalities and deliver on the Core20PLUS5 approach.
- Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialities).

Start date: April 2023

Primary Care Board

PRI1 - Optimising access to primary care

- Implementation of the access recovery plan which will improve access to primary care through focussing on cloud-based telephony, reviewing models of care through capacity and demand.
- Roll out of new online consultation system.

Population Outcome link: N/A

System Goal link: Goal 1 reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks.

Start date: October 2022

PRI2 – 24 / 7 integrated primary care services

Enhanced Access Service (since October replacing GP Extended Access).

Population Outcome link: People's same day care needs are met wherever they present (if possible) and where they need to be cared for elsewhere this feels seamless and integrated.

Population Outcome link: N/A

System Goal link: Goal 1 reduce preventable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks.
- Continue the trajectory to deliver 50 million more appointments in General practice by the end of March 2024.

Start date: April 2023

PRI3 - Annual Health Checks for people with a learning disability

Focus on those patients who have not received an annual health check in previous 18 months (Quality Improvement Scheme).

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness)

West Yorkshire 10 Big Ambition link: 10% reduction in the gap in life expectancy between people with mental health conditions, a learning disability and / or autism

Impact on NHS national objective: Ensure 75% of people over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024.

Start date: April 2023

PRI4 - Dementia Diagnosis

Practices to review their dementia prevalence rate and identify patients at clinical risk of dementia and offer assessment and referral (Quality Improvement Scheme).

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness)

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: Recover the dementia diagnosis rate to 66.7%.

Start date: April 2023

PRI5 - Increasing the primary care workforce including the Additional Roles Reimbursement scheme

Delivery of the Primary Care Workforce Action plan including increasing the number of Additional Roles Reimbursement Scheme (ARRS) employed workforce, developing recruitment and retention measures, supporting the health and wellbeing of the workforce to support increasing capacity of primary care services.

Population Outcome link: N/A

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Continue to recruit 26,000 Additional Roles Reimbursement Scheme roles by the end of March 2024.
- Continue the trajectory to deliver 50 million more appointments in General practice by the end of March 2024

Start date: April 2023

PRI6 - Increase uptake of vaccinations and immunisations (including flu and COVID)

Continue to support the delivery of all the vaccination programmes.

Population Outcome link: N/A

System Goal link: Goal 2 increase early identification and intervention (of both risk factors and actual physical and mental illness)

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: N/A

Start date: N/A

Same Day Response Care Delivery Board

SDR1 - Same Day Response (reducing people attending A&E) - PCAL+ Creating a new single gateway that brings together the Primary Care Advice Line (PCAL) and the Single Point Urgent Referral (SPUR) & Yorkshire Ambulance Service (YAS) push model

Working with YAS in testing out their ability to identify and 'push' referral to Urgent Community Response (UCR) via SPUR as clinically triaged from the ambulance stack and then secondly assessing the impact of primary / community clinicians 'pulling' patients from the stack and providing an UCR response.

Population Outcome link:

- People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs.
- People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Improve A&E wating times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
- Reduce adult general and acute bed occupancy to 92% or below.

Start date: In progress.

SDR2 – Same-Day response (reducing people attending A&E) - Children Urgent Care

Paediatric ARI hub – Community Ambulatory Paediatric Service (CAPS) service aims to provide same day provision for children that have been clinically assessed / triaged as requiring face to face physical examination and present with respiratory symptoms.

Population Outcome link:

- People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs.
- People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Improve A&E wating times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024 / 2025.
- Reduce adult general and acute bed occupancy to 92% or below.

Start date: December 2022

SDR3 – Same-Day Response (reducing people attending A&E) - Maximise Primary Care Advice Line

Avoid unnecessary ED attendances by facilitating healthcare providers to get patients to the right place for their care sooner to enable better patient outcomes and experience. The service currently has access to approximately 50 same day emergency care pathways within LTHT.

Population Outcome link:

- People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs.
- People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: improve A&E wating times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024 / 2025.

Start date: In progress.

SDR4 – Same-Day Response (reducing people attending A&E) – Developing Same Day Emergency Care

Same Day Emergency Care (SDEC) aims to reduce admissions and ED attendances by providing timely assessment, diagnosis, and treatment, improving patient experience and care.

Population Outcome link:

- People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs.
- People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.
- Care is high quality, person centred and appropriated to people's same day needs now, whilst considering how these might change in the future.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Improve A&E wating times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024 / 2025.
- Improve category 2 ambulance response times to an average of 30 minutes across 2023 / 2024 with further improvements towards pre-pandemic levels in 2024 / 2025.

Start date: In progress.

SDR5 - Urgent community response.

Enhanced Community Response is to deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to Emergency Department (ED) attendance / admissions to hospital; shorten length of stay. Workstreams include:

- Same Day elements – Two-hour Crisis Response offer, Telecare Rapid Falls Response
- Virtual Wards (Hospital)

Population Outcome link:

- People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs.
- People's same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective:

- Improve A&E wating times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024 / 2025.
- Reduce adult general and acute bed occupancy to 92% or below.
- Consistently meet or exceed the 70% two-hour community response standard.

Start date: In progress.

SDR6 - BARCA – high volume service user service

The BOST service works with service users and providers to identify the root cause of urgent and same day services high volume service use and work to resolve these causes. The exact intervention(s) needed for each individual cannot be prescribed (due to the potentially diverse requirements), but the focus should be on reducing UEC usage and overall system spend on this group of service users.

Population Outcome link:

- People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned same day needs.

- People’s same day care needs are met wherever they present (if possible), and where they need to be cared for elsewhere, this feels seamless and integrated.

System Goal link: Goal 1 reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well.

West Yorkshire 10 Big Ambition link: N/A

Impact on NHS national objective: improve A&E wating times so that no less than 76% of patients are seen within four hours by March 2024 with further improvement in 2024 / 2025.

Start date: In progress.