Leeds Health & Care Partnership

The Healthy Leeds Plan

2023 - 2028

Contents

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The Healthy Leeds Plan

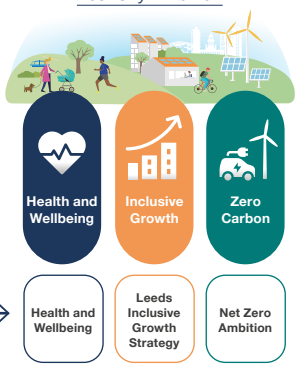
The Healthy Leeds Plan, sets out the contribution of health and care partners toward achieving the vision of the Leeds Health and Wellbeing Strategy. It is intended as an iterative plan and will adapt as our population changes and our city's capabilities evolve and grow. Our summary on a page provides a visual summary of the key components that make up the plan and provides links to key sections within it.

See ***Introduction*** and ***Our City and Vision*** for more

Our vision **(Health and Wellbeing Strategy)**: Leeds will be a healthy and caring City for all ages where people who are the poorest improve their health the fastest

What health and care partners will do to meet this vision (Healthy Leeds Plan) –

Three pillars of our *Best City Ambition*



See ***Our goals*** to understand why we are focusing on these two areas

Our Goals:

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

Focused on: **26%** of population in Leeds who live in the **10%** most deprived areas nationally.

See ***Identifying Our Strategic Initiatives*** for more detail on why and how these were identified as possible priority areas for making an impact on our goals

Drawing on analysis from the Leeds Data Model, there are five emerging areas where we feel we can make an impact on our goals.

- Children and Young People: Respiratory Disease
- People with three or more Long Term Conditions and Serious Mental Illness
- Frailty and Cancer Populations: Injury / Fracture
- End Of Life Population: Respiratory Disease
- Intermediate Care Provision (HomeFirst Programme)

See ***Population Health Infrastructure*** for information on the Population Boards. Also see ***Our Plans*** and ***Appendix One and Two*** to understand the work underway in Leeds (guided by these boards) and how this delivers on national requirements.

Our city's population health Infrastructure will enable us to drive change in the areas above, alongside delivery of national priorities and improvement work underway within individual organisations

All of this is supported by a set of enabling skills and capabilities

See ***enablers*** section

Workforce | **Research & Academia** | **Leadership & Culture** | **Data & Intelligence** | **Digital** | **Estates** | **Quality Improvement** | **Financial Stewardship** | **Communications & Involvement**

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 *(Leeds Health and Wellbeing Strategy)*. 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)*.

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* and the *NHS Long Term Plan*.

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 (see Fig. 1) 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 (WYHCP) 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* 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*, *Local Care Partnerships (LCPs)* and the executive meetings of the West Yorkshire ICB.

Fig 1: The Health and Care Partnership in Leeds

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*, 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* 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)*.

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

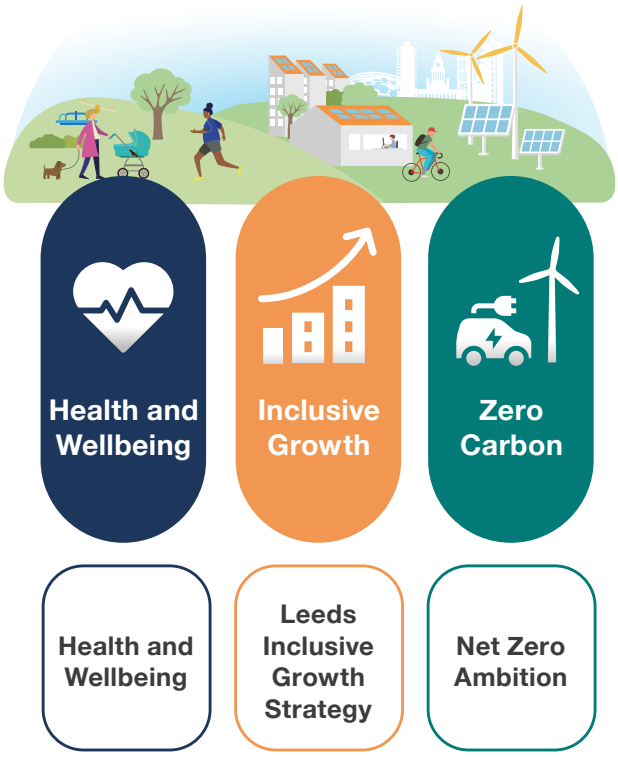
The Leeds Inclusive Growth Strategy sets out how we can make Leeds a healthier, greener and more inclusive economy that works for everyone

The Net Zero Ambition sets out our commitment to be carbon neutral

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*.

Three pillars of our *Best City Ambition*



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)* 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

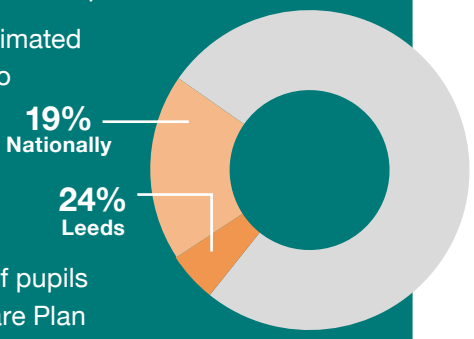
- Our population has been expanding, specifically within our inner-city areas which are often our most deprived communities. These communities experience our city's worse health outcomes.
- There is a 14-year life expectancy gap for women and a 12-year life expectancy gap for men between some of our 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.

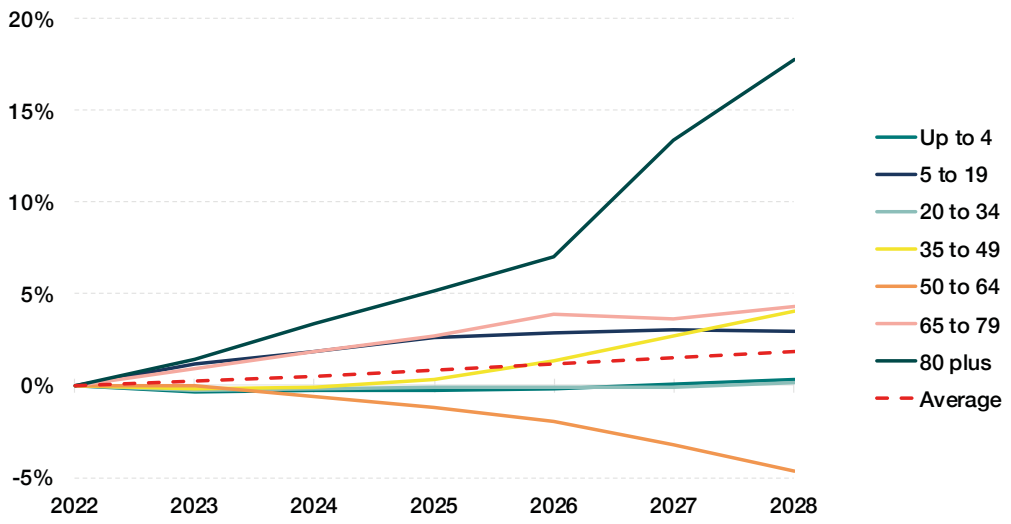
An increase in people experiencing mental health issues

- 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 5 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.

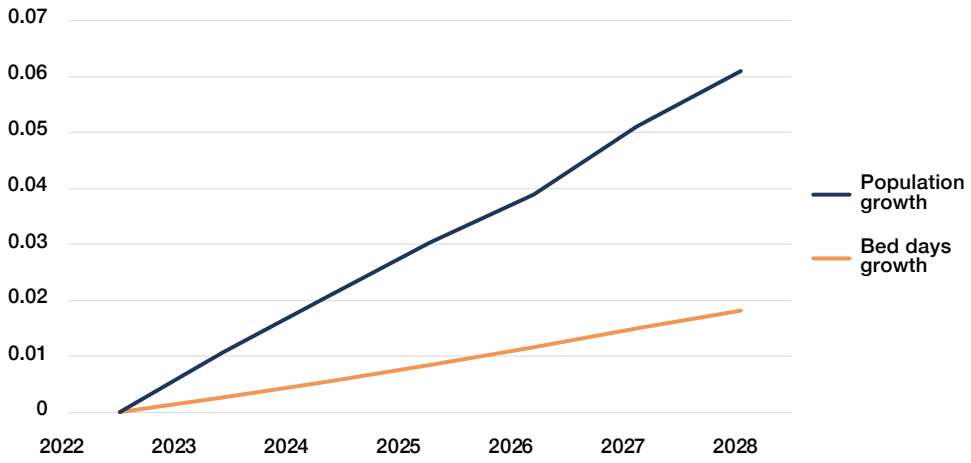
Looking at the overall population size and age-distribution (excluding deprivation effects) provides an indication of the likely future health and care demand expected in Leeds. The Office for National Statistics (ONS) provides a forecast of the population changes from 2022 to 2028, shown in figure 2 below.

Fig 2: ONS Projected population changes by age-group from 2022



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. This is provided in figure 3 below, which shows likely changes in unplanned care utilisation (using acute admissions data).

Fig. 3 Acute Admissions Activity Growth (bed days) vs. Population Growth

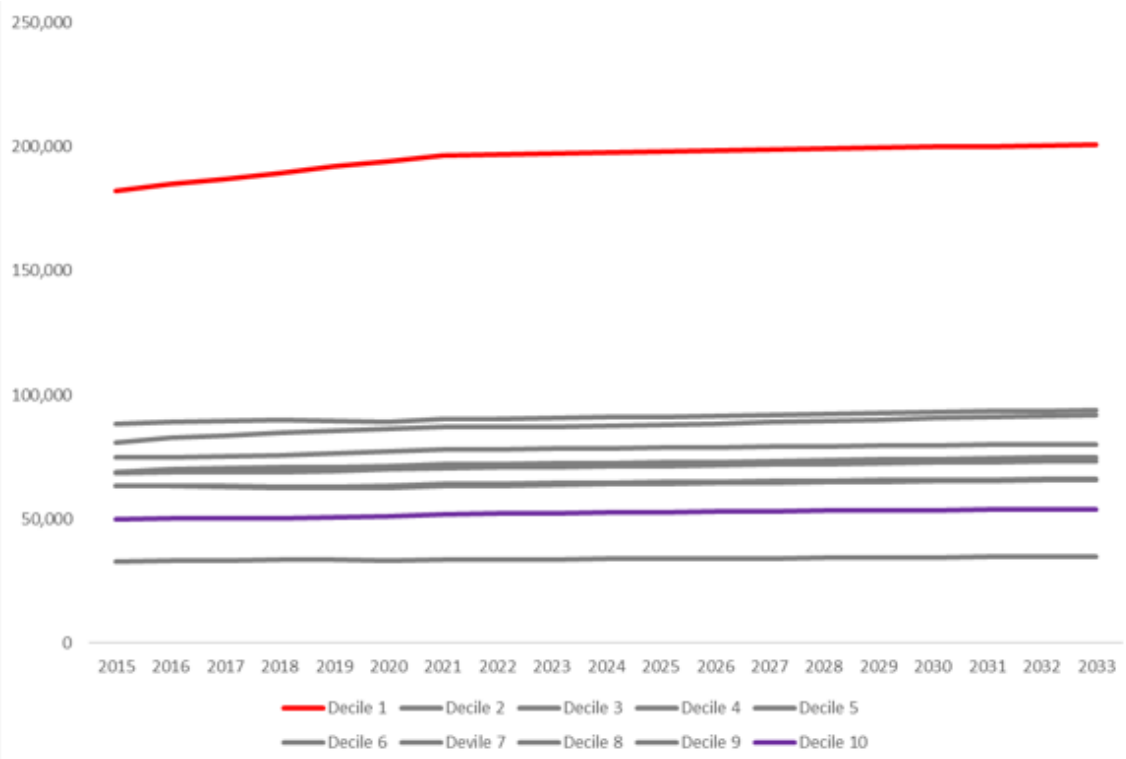


To meet our citywide vision, given these challenges, we must start to understand and respond to future population need now. In delivering our Healthy Leeds Plan, we will apply an evidence-based, population health approach to drive innovation and deliver person-centred, integrated health and care for 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.

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 (see figure 4), and this is more significant within the younger age populations.

Fig 4: Population trends by deprivation decile

Population Trend (all ages and sex) by Deprivation Decile, 2015 to 2033



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:

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

Focussing on the 26% of the population in Leeds who live in 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 consists of four parts:

Unplanned acute admissions (bed days)

A&E attendances including Walk in and Urgent Treatment Centres (number of attendances)

Access to specialist mental health crisis services (number of attendances)

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 (PPS)

In 2014, *Staten Island PPS* (SI PPS) 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; 20+ community organisations and 3600 primary care practitioners.

Approach

SI PPS model utilised a data-driven approach that focussed on a 'System of Care' methodology. The SI PPS created an advanced population health management ecosystem that monitored outcomes of care at an individual, practice and population level. The platform's geo-mapping 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 PPS, 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.

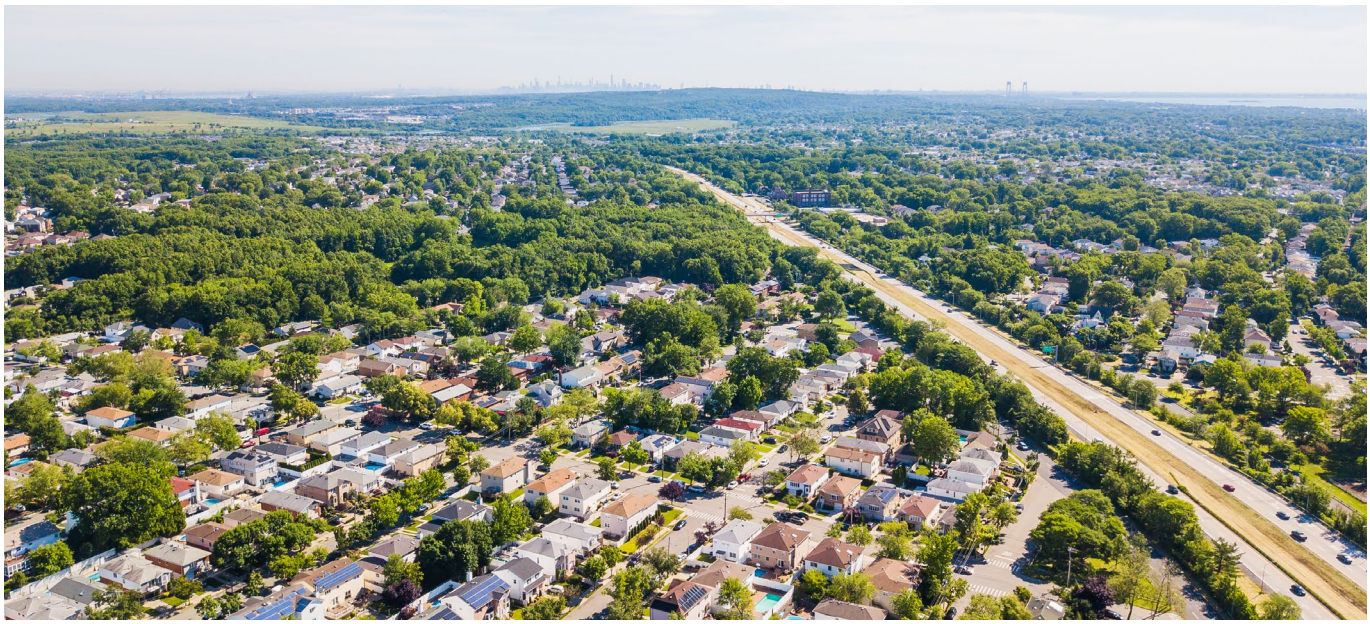
Overall achievements of the Staten Island PPS Model

The approach used by SI PPS 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 2023/24.

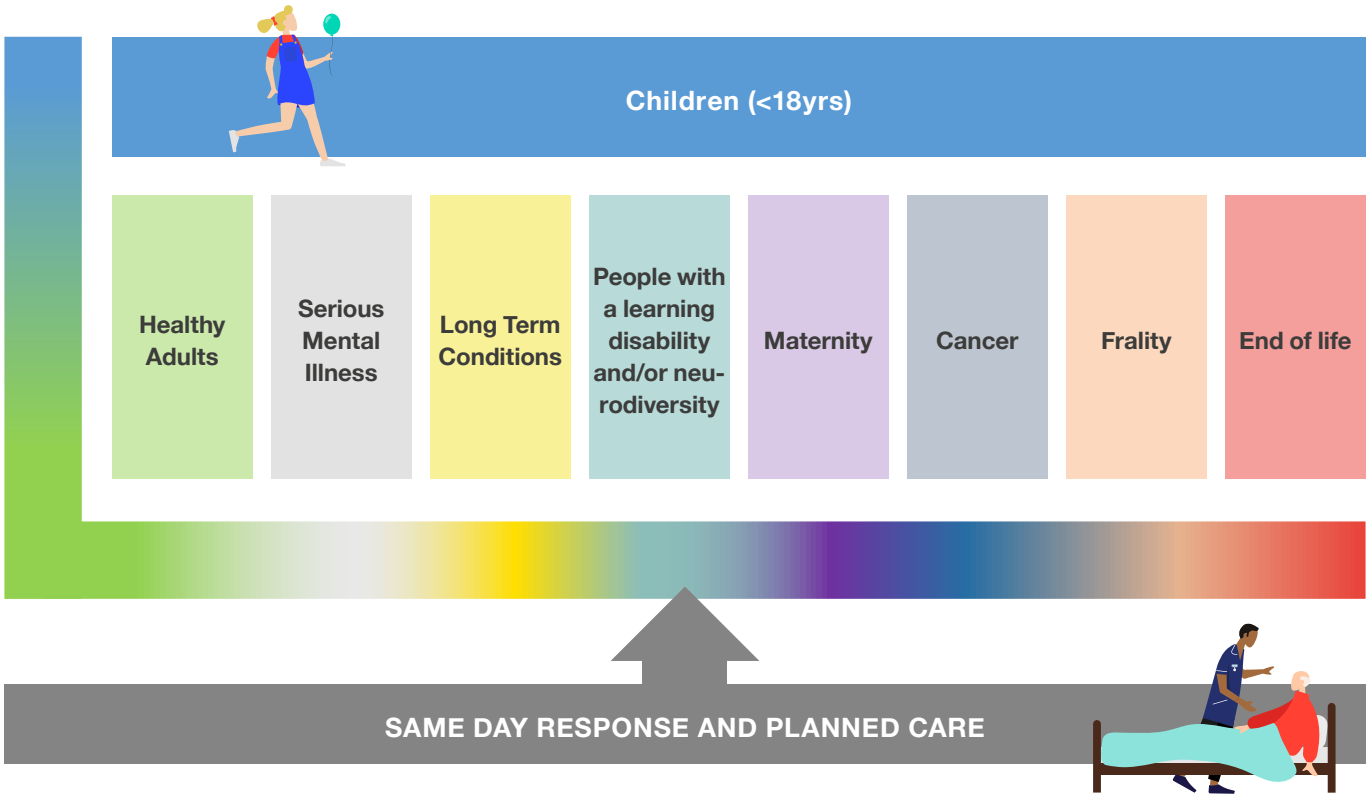
Population Health Infrastructure
(to support delivery of our goals)

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.
- 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.

Fig. 5: Leeds population segments



The Leeds Data Model

- The Leeds Data Model (LDM) 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*.
- 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 (LCPs)* bring together a range of partners within Leeds to champion co-ordinated holistic person-centred care and address community priorities within the context of a wider health and wellbeing partnership.
- LCPs 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 LCPs focus on their local communities and implementing solutions to meet the needs of the local community.
- LCPs 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.

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

- The Tackling Health Inequalities Group (THIG) 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.
- THIG 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.
- THIG 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.
- Whilst the Population and Care Delivery Boards are accountable for addressing health in equalities for their populations, THIG 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)* 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.

Fig. 6: Leeds and the areas of the most deprived 10% nationally

English decile	Leeds pop.	% of Leeds
English top 10%	**226,013**	**26%**
2	82,285	9%
3	78,288	9%
4	35,384	4%
5	91,191	10%
6	72,545	8%
7	93,652	11%
8	66,848	8%
9	68,490	8%
10	56,036	6%

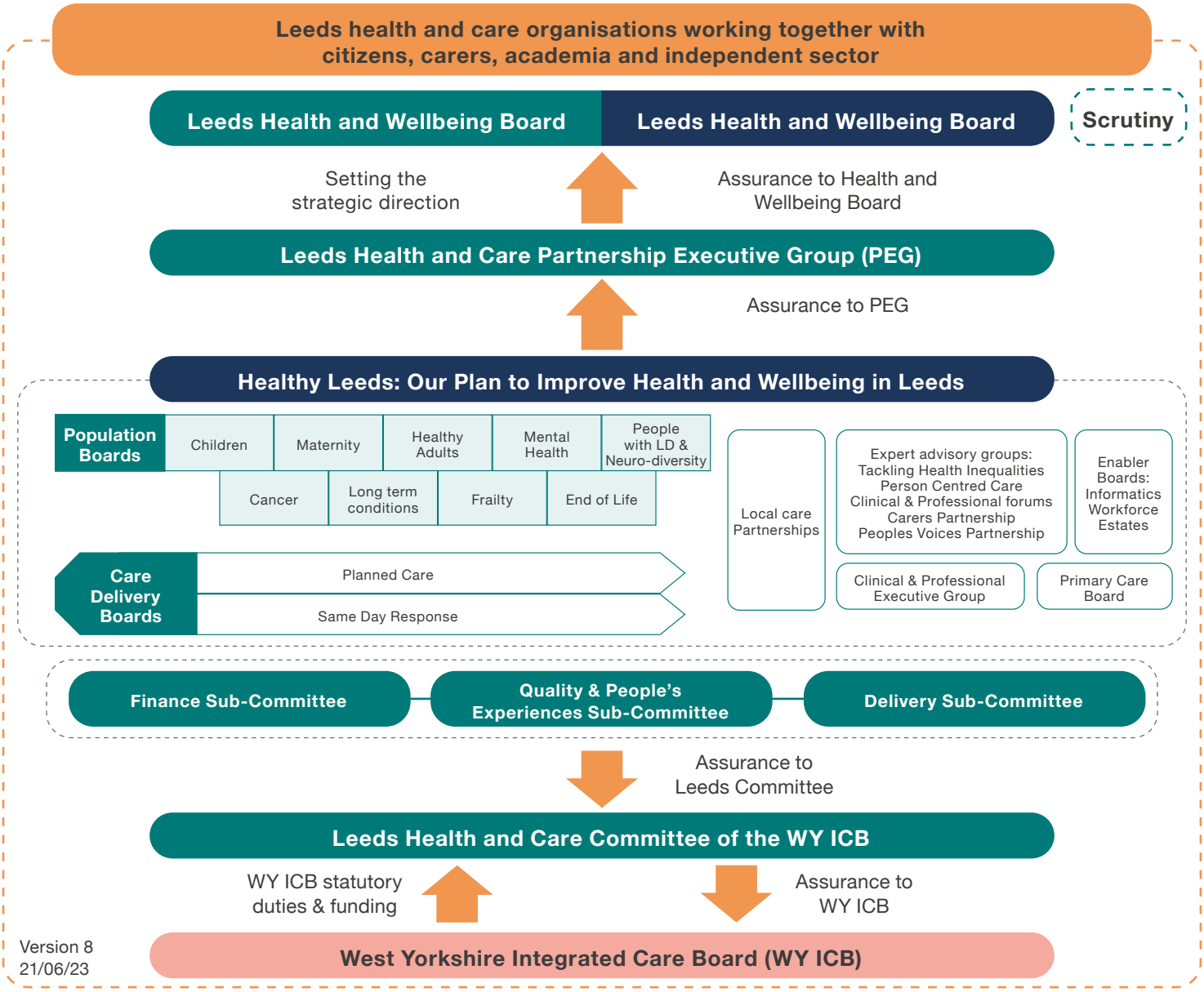
IMD2019 and October 2020 Leeds 2020 Leeds registered populations.

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 cities 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 3rd sector, General Practice and Clinical Senate.

Our governance structure is illustrated below.

Leeds Health & Care Partnership Governance Structure



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

The 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 codesigned 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.*

The Tackling Health Inequalities Group (THIG), 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 (PVP) 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 PVP 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 PVP 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 *LHCP website*.

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, coproduction 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 (ODA) has developed an initial methodology to identify areas of opportunity to improve health and wellbeing, drawing on the capability of our Leeds Data Model (LDM).

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 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.

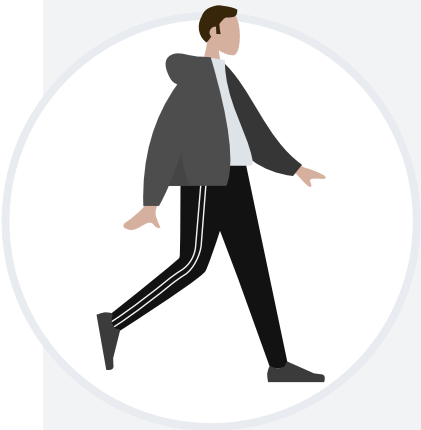
This methodology will be improved and refined over the next year, including a broader range of metrics from Goal 1 and drawing on more powerful analytical techniques to identify further areas of opportunity. However, the data analysis has indicated several areas for Leeds to consider during 2023/24 as potential areas of focus where we can make a difference and improve outcomes for our population. These are summarised in the next section.

Strategic Initiatives

Children and Young People: Diseases of the respiratory system

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 these areas the average length of stay is 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 the people aged under 18 are the fastest growing population in IMD1 and that investment in prevention for this population is important to support them in leading healthy lives in the future.

This priority aligns with the Children and Young People's Core20PLUS5 framework, which identifies Asthma as one of the five clinical areas of focus that requires accelerated improvements.



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

Data analysis indicated 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, through the data, that 60% of this cohort are obese and 32% are smokers. We also know, through evidence based methodologies that these conditions are likely to be amenable to improvement via person-centred, proactive care.

Serious Mental Illness and multiple Long Term Conditions are plus groups within the Core20PLUS5 national programme. Three of the five clinical areas identified within the Core20PLUS5 programme that require accelerated improvements, are also 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. 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. Data indicates that people, when admitted following an injury or fall and living within areas of IMD 1, are on average likely to stay in hospital 5.5 days longer than people in other areas.

This is also replicated within the Cancer population segment. 79% of people within the cancer segment and living within IMD 1 having a non-elective bed day for injuries / fractures are also living with frailty, with over 40% living with severe frailty. Therefore, given a significant number of people in IMD 1 in the cancer segment with a non-elective admission for injuries / falls would have been in the frailty segment if they did not have cancer, it is suggested that the Cancer Population Board and Frailty Population Board work together in this area.

End of Life Population: Diseases of the Respiratory System

The End of Life population segment is our smallest population in size but represents the fourth highest number of bed days in total and the highest rate of bed days per 1,000 population. The rate of bed days per 1,000 population is higher for 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 will be taken forward through the End of Life Population Board with input from the Long Term Conditions and Frailty Population Boards as well as our Local Care Partnerships.

HomeFirst Programme

Alongside these priority areas the Partnership has agreed an additional focus on improving system flow overall - 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:

- 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 independence and long term care needs.

The HomeFirst programme (formally the Intermediate Care Programme) represents our fifth priority area 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, helping more people to stay at home, whilst improving the experience 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, with improvement 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 from a short-term bed;
- 100 more people able to go home after their time in intermediate care.

(all per 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 from other deprivation deciles. People living with dementia are at least twice as likely to access intermediate care as the average person over 80 or the frailty population. Patients living with dementia have a higher re-admittance rate to hospital following discharge from 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 within IMD1.

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 2023/24 are built on the premise that the city can achieve substantial in-year savings. The Leeds ICB 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:

- 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;
- The pandemic has driven up demand for health services in most areas above that which we saw before COVID-19 along with significant backlogs; and
- Finally, 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

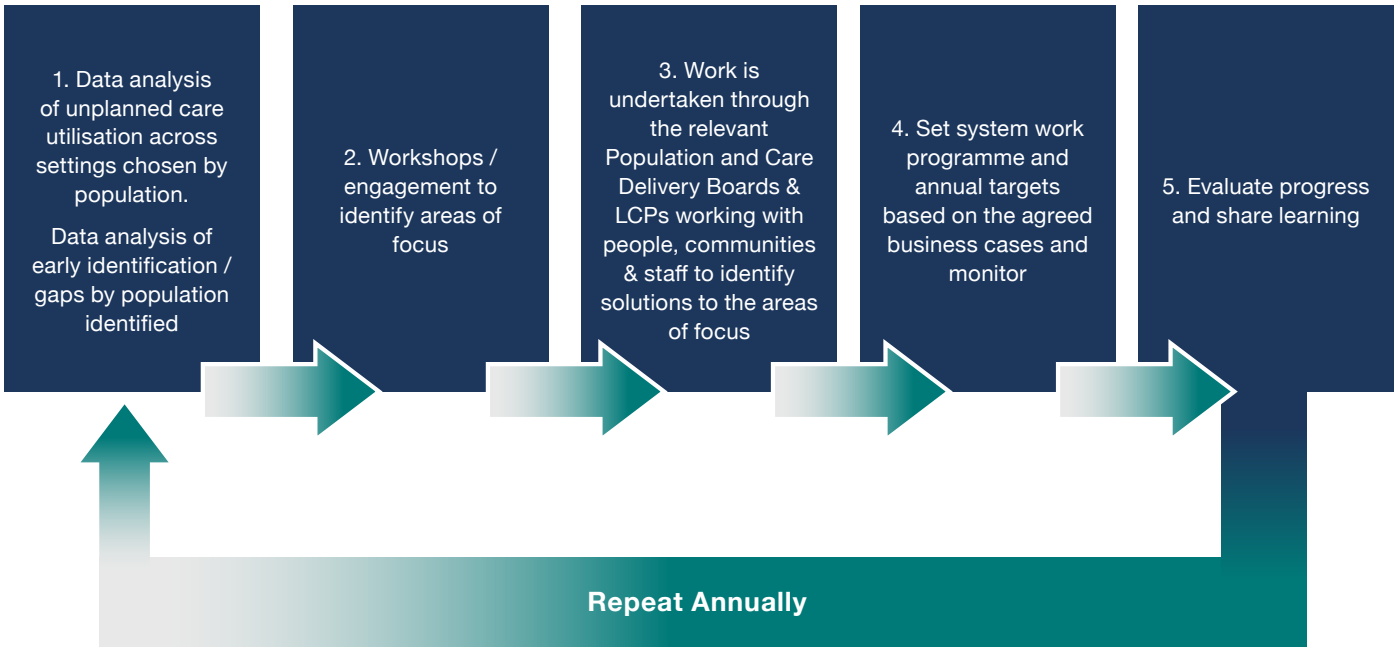
Ensuring success of a focussed approach, as demonstrated by Staten Island model, is not just about the goals themselves but the behaviours that focussing on a goal has led to. Within Leeds we have developed a partnership approach to an annual cycle (see fig. 7), based on the Staten Island model.

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.

Fig 7: Annual cycle



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 Anti-microbial 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 Action Plan. 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 the *Audit of Suicides in Leeds (2014 – 2016)* and *Preventing Suicide in England* reports. 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.

Population	**Population definition**	**Population size**
Children and Young People	All Leeds residents under the age of 18	177,712*

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	**Children's Mental Health** Crisis offer for CYP from prevention to inpatient stays. Prevention and timely access to services	**Children's System Flow** Develop proactive and reactive model to ensure children are seen at the right time in the right place Community Hubs Children's Virtual Ward
NHS national priorities	Improve access to mental health support for children and young people (0-25 years)				
Core20PLUS5	Focus on the most deprived communities and plus groups Asthma, Diabetes, Epilepsy, Oral health and Mental health				

WYICS 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

WY programmes

- Supporting our children, young people and families

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

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

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Maternity	People over 18 and pregnant or within 2 years of a pregnancy	12,777*

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 10 weeks	**Maternity and Neonatal Voices Partnership (MNVP)** Accessible and close to home care service user engagement Staff satisfaction / feedback	**Gestational diabetes & 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

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

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.

WYICS 10 Big Ambitions:

- Reduction in stillbirths, neonatal deaths, brain injuries

WY programmes

- Maternity services

Health and Wellbeing Strategy (2023-2030):

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

Local strategies and plans

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

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Healthy Adults	People 18+ with no diagnosed long-term conditions and not pregnant	343,243*

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**	**Healthy Body**	**System Flow**	**People supported to live well**	**Tackling Health Inequalities (Core20PLUS5)**	**Health Inclusion**
	Data led approach to targeted interventions for those at greatest risk of developing anxiety. depression and risk of suicide	Data led approach to targeted interventions for those at greatest risk of developing hypertension, diabetes, liver disease and osteoarthritis	Out of Hospital Project for those with no fixed abode/ multiple complex disadvantages Social Prescribing in A&E Home Plus Service	Social Prescribing for non-clinical health and wellbeing needs Social Prescribing in A&E Digital Health Hubs	Community Grant schemes via Local Care Partnerships Development of Core20PLUS5 data lenses for all boards Development of models best practice to design and implement interventions to tackle inequalities	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) Development and synthesis of qualitative data for health inclusion group access, experience and outcomes of care.

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
Core20PLUS5	Focus on the most deprived communities and plus groups

Local strategies and plans:

- *Leeds Drug & Alcohol strategy*
- *Leeds Best City ambition*
- Inclusive Growth strategy
- Marmot City Ambition

Health & 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

WYICS 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%

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Learning Disabilities and Neurodiversity	Diagnosis of a learning disability and/or Autism	5,180*

Outcomes	Appropriate early identification of a Learning Disability and/or Neurodiversity	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

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, people with a learning disability and autistic people.
  - Digital Reasonable Adjustment Flag

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 or autism.

WYICS 10 Big Ambitions:

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

WY programmes

- Mental Health, Learning Disabilities and Autism

Health and Wellbeing Strategy (2023-2030):

- 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

Local strategies and plans

- Being Me strategy
- Leeds Autism strategy

**from the LDM and based on the population definition criteria*

Population	Population definition	Population size
Serious Mental Illness (SMI)	Over 18 and with a diagnosis of Serious Mental Illness	12,452*

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

Crisis Pathway Redesign implementation

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 2 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**.

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

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).

WYICS 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

WY programmes

- Mental Health, Learning Disabilities and Autism

Health and Wellbeing Strategy (2023-2030):

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

Local strategies and plans

Leeds Mental Health strategy

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Cancer	Diagnosis of cancer	27,806*

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** 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** • **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

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
Core20PLUS5	• Early Cancer Diagnosis	

WYICS 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.

Health and Wellbeing Strategy (2023-2030):

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

Local strategies and plans

- Leeds Cancer Programme
- LTHT Cancer work
- West Yorkshire cancer alliance

**from the LDM and based on the population definition criteria*

Population	**Population definition**	**Population size**
Long Term Conditions	Over 18 with a diagnosis of qualifying long-term condition (e.g. diabetes, asthma) and not in any other segment	242,528*

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

Key workstreams	**Integrated Weight Management**	**Multi-morbidity (3 LTCs Plus MH)**	**CVD**	**Respiratory**	**Neurology**	**Diabetes**
	Integrated weight management model development Nutrition and Dietetics / Enteral feeds / Oral Nutritional Supplements	• Develop secondary prevention MDT / multimorbidity hub ambition • Long covid review • Rehabilitation model development • Self-management • Cardio-renal-metabolic (CaReMe) • Digital remote monitoring	• Lipids Maintenance Hypertension • Remote monitoring/ self-management • Anticoagulation and thrombosis • Integrated Heart Failure model next Steps	• Home Oxygen delivery across Yorkshire and Humber • Community intravenous service (CIVAS) • Diagnosis and prescribing • Asthma prescribing • Spirometry and contribution to diagnostic hubs	• Stroke • Community Neurological Rehab Service (CNRS) redesign • Multiple sclerosis (MS), Epilepsy, Functional Neurological Disorder (FND) and Motor Neurone Disease (MND)	• National Diabetes Prevention Programme (NDPP) • Diabetes Remission • NHS Treatment and Care performance • Chronic Kidney Disease (CKD) • Continuous Glucose Monitoring (CGM)

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 percent 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.
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.	

WYICS 10 Big Ambitions:	**Health and Wellbeing Strategy (2023-2030):**	**Local strategies and plans**
We will increase the years of life that people live in good health **WY programmes** Supporting Long Term Health Conditions	• 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	• *Leeds Diabetes Strategy* • *Leeds Stroke Priority Report*

**from the LDM and based on the population definition criteria*

Population	Population definition	Population size
Frailty	Over 60 AND Electronic Frailty Index (eFI) score >= 5	62,381*

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 peoples lives as a result of contact with services

Key workstreams	**Home First Programme** Review of intermediate care services and pathways / processes to reduce delays	**Dementia needs** Coordinated 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

NHS national priorities	• 2-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

Core20PLUS5	Focus on the most deprived communities and plus groups

WYICS 10 Big Ambitions:	**Health and Wellbeing Strategy (2023-2030):**	**Local strategies and plans**
We will increase the years of life that people live in good health **WY programmes** Supporting people leaving hospitals and developing integrated step-up and step-down intermediate care services	• 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	• Age Friendly Leeds

**from the LDM and based on the population definition criteria*

Population	Population definition	Population size
End of Life	Over 18 and on palliative care register	3,095*

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.
Core20PLUS5	Focus on the most deprived communities and plus groups					

WYICS 10 Big Ambitions:

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

WY programmes

Palliative and end of life care

Health and Wellbeing Strategy (2023-2030):

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

Local strategies and plans

- *Leeds Adult Palliative and End of Life Care Strategy 2021-2026*

**from the LDM and based on the population definition criteria*

Population
Same-Day Response

Population definition
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 PCAL 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** • 2 hour crisis response offer • Telecare Rapid Falls response • Virtual wards (hospital at home and remote monitoring)

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
Core20PLUS5	Focus on the most deprived communities and plus groups

WYICS 10 Big Ambitions:

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

WY programmes
Same Day emergency care

Health and Wellbeing Strategy (2023-2030):

The best care at the right place at the right time

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

Population
Planned Care

Population definition
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 recovery** • Community Gynae re-design • Procurement Community Ophthalmology Services • Procurement ENT & 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

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
Core20PLUS5	Focus on the most deprived communities and plus groups across core clinical areas

WYICS 10 Big Ambitions: We will increase the years of life that people live in good health **WY programmes** Recover and transform planned care services	**Health and Wellbeing Strategy (2023-2030):** • 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	**Local strategies and plans** NHS planning submission for planned care, diagnostics and outpatients

Population
Primary Care

Outcomes	Improved care experience for patients 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 (CVD) 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 LD** 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 identity 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

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).
Core20PLUS5	Focus on the most deprived communities and plus groups	

WYICS 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

WY programmes
Primary care transformation

Health and Wellbeing Strategy (2023-2030):
- 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

Local strategies and plans
- Core GP Contract
- Fuller Stocktake
- Access Recovery Plan
- PCN Directed Enhanced Service

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 & Developing Registrants, 3. Working Across Organisations 4. Preventing ill-health 5. Narrowing Inequalities and 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 (PVP) 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 peoples voices at the centre of decision making.

The Strategic Communications Group (SCG), and its supporting Operations group (OCG), 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.

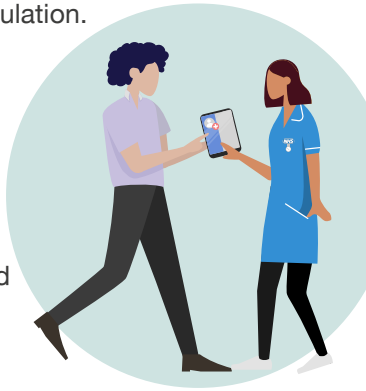
Leadership and culture

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, is 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 to provide 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:

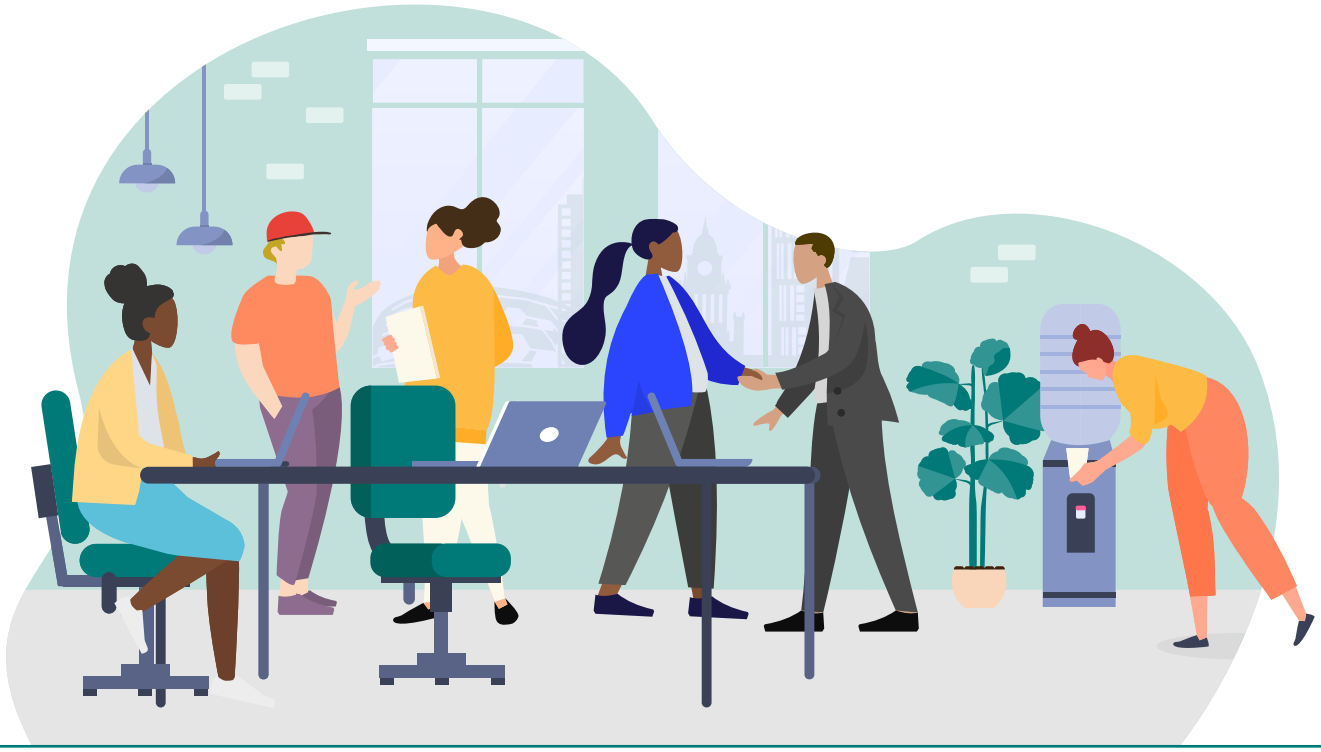
- using data (disaggregated by deprivation and key demographic variables) to identify and eliminate inequities;
- introducing new ways to stay healthy including education and services; and
- ensuring that all children can access and use technology.

Living and ageing well: using new technologies to deliver health and wellness services tailored for individuals and ensure that peoples 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; and
- 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; and
- 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 where 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 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.

Plenary 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.

Appendix One:
Leeds Operational Plan - Anticipated trajectories for National Indicators

Appendix Two:
Leeds Operational Plan Implementation

Leeds Health & Care Partnership

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.

Please note – the code next to each intervention sets out where in the document you can find more detail on that intervention in appendix 2. For example – CAN1 is the first intervention listed in the Cancer implementation plan that can be found in appendix 2.

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
1	**Urgent and Emergency Care -** 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 2024/25	76.5% (April 23)	76%	• Enhanced Community Response - deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to ED attendance/admissions to hospital (SDR1) • Covid Urgent Eyecare Service (CUES) (PC3) • Social prescribing in A&E (HA4) • PCAL+ Creating a new single gateway that brings together the Primary Care Access Line (PCAL) and the Single Point Urgent Referral (SPUR) & Yorkshire Ambulance Service (YAS) push model (SDR1) • Enhanced Care at Home - Improving our urgent community offer to support people at home and reduce unplanned admissions (HF1) • Active Recovery at Home - Increasing the number of people who are able to be supported at home following hospital discharge (HF2) • Rehab and Recovery Beds - optimising and recommissioning intermediate care beds in Leeds (HF3) • Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time (HF4) • Community Ambulatory Paediatric Service (CAPS) – (SDR2)	Same Day Response Board and System Flow Steering Group

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
2	**Urgent and Emergency Care -** Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	34 minutes – YAS footprint wider than Leeds area (March 23)	Not reported at place level	• Many of the above areas will contribute towards this • Yorkshire Ambulance Service (YAS) regional transformational work which includes expanding capacity, transforming services and improving efficiencies.	Same Day Response Board
3	**Urgent and Emergency Care -** Reduce adult general and acute (G&A) bed occupancy to 92% or below	98.1% (April 23)	98% (Occupancy of 92% not possible given level of demand, with any further reduction used to support elective recovery)	• Out of Hospital Project for those with no fixed abode / multiple complex disadvantages (HA1) • PCAL+ Creating a new single gateway that brings together PCAL and SPUR & Yorkshire Ambulance Service (YAS) push model (SDR1) • Community Ambulatory Paediatric Service (CAPS) – (SDR2) • Enhanced Community Response - deliver urgent community response services aiming to reduce disruption to people's lives via alternatives to ED attendance/admissions to hospital (SDR4) • Active Recovery at Home - Increasing the number of people who are able to be supported at home following hospital discharge (HF2) • Rehab and Recovery Beds - optimising and recommissioning intermediate care beds in Leeds (HF3) • Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce the non-value-added time (HF4)	System Flow Steering Group
4	**Community Health Services** - Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	56% (March 23)	70%	• Enhanced Community Response (SDR1) • Enhanced Care at Home - Improving our urgent community offer to support people at home and reduce unplanned admissions (HF1)	Same Day Response Board / Frailty Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
5	**Primary Care -** Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	No measure	No measure	• Children's system flow (CYP2) • Digital - remote monitoring implementation for 3 plus LTCs and mental health (LTC1) • Long Covid review and rehabilitation model development (LTC2) • A number of respiratory initiatives including MART (maintenance and reliver therapies), Expansion of pulmonary rehab, Spirometry next steps (LTC3) • CUES (Covid Urgent Eyecare Service) (PC3) • Advice and Guidance (PC10) • Ophthalmology re-procurement (PC8) • Social Prescribing (HA4) • Community digital health hubs (HA3) • Integrated Weight Management (LTC10) • Multimorbidity (3 LTCs Plus MH) - delivery of Diabetes Steering Group Work (LTC4)	Primary Care Board
6	**Primary Care –** 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	81.4% (February 23)	Anticipated target to be established	• Enhanced Access service (PRI2)	Primary Care Board
7	**Primary Care -** Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	4,980k (March 23)	5,019k	• Implementation of the access recovery plan (PRI1) • Delivery of the Primary Care Workforce Action plan (PRI5)	Primary Care Board
8	**Primary Care -** Continue to recruit 26,000 Additional Roles	295 WTE (April 23)	515 WTE by December	• Delivery of the Primary Care Workforce Action plan (PRI5)	Primary Care Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
	Reimbursement Scheme (ARRS) roles by the end of March 2024				
9	**Primary Care -** Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	To be reported on at a West Yorkshire Level			
10	**Elective Care** - Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	715 (March 23) – was not a requirement for 22/23	0	• Ophthalmology re-procurement (PC8) • ENT and Adult Hearing Loss re-procurement (PC4) • Gastro re-procurement (PC5) • Reduction in outpatient follow up (PC11) • Advice and Guidance (PC10) • Waiting well for Planned Care (PC13)	Planned Care Board
11	**Elective Care** - Elective activity levels as a proportion of 19/20 activity reaching 108%	N/A	106.5%	• Increased use of Patient Initiated Follow Up (PIFU) (PC9) • ENT and Adult Hearing Loss re-procurement (PC4) • Reduction in outpatient follow up (PC11)	Planned Care Board
12	**Cancer** - Continue to reduce the number of patients waiting over 62 days	329 (February 23)	288 people	• 2 week wait (2ww) frailty assessment clinics (CAN10) • Optimal Pathways: Head and Neck, Gynae, Prostrate, Bladder, Lung, Skin, Colorectal, Upper GI, Pancreas (CAN11) • MDT Streamlining (CAN11)	Cancer Board
13	**Cancer** - 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	75.5% (March 23)	75%	• Implement faecal immunochemical test (FIT) (CAN1) • 2ww frailty assessment clinics (CAN10) • Open Access Chest X-ray (CAN4) • Practice Nurse Training enable to request chest x-rays (CAN5) • Brain and central nervous pathway – developing a straight to test pathway (CAN6) • Teledermatology (CAN3) • Optimal Pathways: Head and Neck, Gynae, Prostrate, Bladder, Lung, Skin, Colorectal, Upper GI, Pancreas (CAN11)	Cancer Board
14	**Cancer** - Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the	56% (December 22) – WY footprint wider than Leeds area	Place data not available	• Pinpoint blood test (CAN2) • Teledermatology (CAN3) • Implementation of breast pain clinic (CAN8)	Cancer Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
	75% early diagnosis ambition by 2028			• Implement FIT (CAN1) • Open Access Chest X-ray (CAN4) • Practice Nurse Training enable to request chest x-rays (CAN5) • Brain and central nervous pathway – developing a straight to test pathway (CAN6)Lung screening (CAN11)	
15	**Diagnostics -** Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	90.4% (February 23)	95%	• Community diagnostic centres in Seacroft Hospital, Armley and Beeston Medical Centres (PC2) • LTHT Transformation Program – Diagnostics (PC12) • Gastro re-procurement (PC5)	Planned Care Board
16	**Diagnostics -** Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	No specific target	No specific target	• Community diagnostic centres in Seacroft Hospital, Armley and Beeston Medical Centres (PC2) • LTHT Transformation Program -Diagnostics (PC12)	Planned Care Board
17	**Maternity** - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	Still birth rate 3.9 per 1000 births (February 23)	Still birth rate <3.5 per 1000 births Neonatal mortality </= 3.55 per 1000 births Maternal mortality (direct causes) 0 Serious intrapartum brain injury </=10 p/a	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 (M1). • Gestational Diabetes – targeted healthy eating and physical activity interventions (M2) • Doulas (M3) • Maternity Mental Health (M4)	Maternity Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
18	**Maternity** - Increase fill rates against funded establishment for maternity staff	Q3 2022 data: Midwifery workforce 342.21 WTE Obstetric workforce 87.82 WTE Neonatal nurses 128.32 WTE Neonatal consultants 11.5 WTE Aesthetic workforce 9 sessions per week	Midwifery workforce – 363.36 WTE Obstetric workforce - 91.62 WTE Neonatal nurses - 151.97 WTE Neonatal consultants – 13 WTE Aesthetic workforce – 12 sessions per week	As a system we are focused on implementing the recommendations through the single delivery plan including the workforce element	Maternity Board
19	**Use of Resources** - Deliver a balanced net system financial position for 2023/24	Description of plan can be found in the main HLP			
20	**Workforce** - 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			
21	**Mental Health** - 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)	8990 rolling 12 months	8800 rolling 12 months	• 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. (CYP1) • Prevention/timely access to services (CYP3)	Children and Young People's Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
22	**Mental Health –** Increase the number of adults and older adults accessing IAPT treatment	7212 (22/23 – Q4)	7202	• Working to reduce waiting times to access NHS Talking Therapies (MH4)	Severe Mental Illness board
23	**Mental Health –** Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	10,275 (February 23)	11,693	• Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships and PCNs (MH1) • Community Mental Health Transformation - Developing and increasing capacity in psychological therapies for people with SMI and more complex needs (MH2) • Community Mental Health Transformation – Developing and testing new workforce roles (MH3) • Early intervention in psychosis pathway - Further develop EIP to incorporate identification and intervention for those with at-risk mental states (MH7)	Severe Mental Illness board
24	**Mental Health –** Work towards eliminating inappropriate adult acute out of area placements	663 bed days (Q2 22/23)	450 bed days	• Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships and PCNs (MH1) • Community Mental Health Transformation - Developing and increasing capacity in psychological therapies for people with SMI and more complex needs (MH2) • Community Mental Health Transformation – Developing and testing new workforce roles (MH3) • Review and evaluation of MH crisis provision and models of crisis alternatives & crisis pathway redesign (MH5)	Severe Mental Illness board
25	**Mental Health –** Recover the dementia diagnosis rate to 66.7%	68.7% (March 23)	68.5%	• Practices to review their dementia prevalence rate and identify patients at clinical risk of dementia and offer assessment and referral (QIS) (PRI4)	Severe Mental Illness board and Frailty board
26	**Mental Health –** Improve access to perinatal mental health services	770 (March 23)	863	• Maternity Mental Health Service (M4)	Maternity Board and Mental Health Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
27	**People with a learning disability and autistic people** - Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	83% (March 23)	75 %	• Annual health checks for people with LD - Focus on those patients who have not received an annual health check in previous 18 months (QIS) (PRI3)	Primary Care Board
28	**People with a learning disability and autistic people** - 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	31 across ICB and NHSE commissioned beds (22/23 Q3)	26 (15 commissioned by the ICB and 11 NHSE / Provider collaborative)	• 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	People with a Learning Disability and Neurodiversity board
29	**Prevention and Health Inequalities -** Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024	65.9% (22/23 Q4)	77%	• Multimorbidity (3 LTCs Plus MH) - delivery of CVD Steering Group Work (LTC5)	Long Term Conditions Board

No	National Planning Objective	Baseline position	Anticipated Position March 2024	Interventions to support achievement	Board Overseeing Progress
30	**Prevention and Health Inequalities -** Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	63.9% (22/23 Q4)	60%	• InHIP project delivery - WY/AHSN funded Health Inequalities project (LTC7) • STF Project Lipids - Project delivery on behalf of WY and Leeds (LTC8)	Long Term Conditions Board
31	**Prevention and Health Inequalities -** Continue to address health inequalities and deliver on the Core20PLUS5 approach	Current performance not available	No specific target yet	• Waiting well for Planned Care (PC13) • LCP community grants, Social Prescribing, SP community of practice, digital health hubs (HA3). • Social Prescribing in A&E; home plus; unplanned care for healthy adults (HA4) • Compassionate Leeds (CYP1) • Prevention/timely access to services for children and young people (CYP3) • Out of Hospital Project for those with no fixed abode / multiple complex disadvantages (HA1) • Women's health programme (HA2)	Within the scope of all boards

Leeds Health & Care Partnership

Appendix Two - Leeds Operational Plan implementation

The following pages describe initiatives that our population and care delivery boards will be overseeing implementation or continued implementation of over the next year to impact on either our place goals, West Yorkshire 10 Ambitions or NHS National Objectives.

Implementation Plan 23/24 Cancer

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
CAN1	Earlier Diagnosis - Implement FIT	Agreeing and implementing a pathway change to incorporate faecal immunochemical test (FIT) testing within the Lower GI 2 Week Wait (2WW) pathway	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 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 demographic to create a cancer risk score for patients attending primary care with symptoms.	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** April 2022
CAN3	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	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** June 2023
CAN4	Earlier Diagnosis – Open Access Chest x-ray	Re-starting 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.	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** September 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
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	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 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 2 week wait referrals	People with cancer in Leeds will be diagnosed earlier when evidence shows this to be beneficial	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 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	People living with cancer will receive person centred care	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	N/A	**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 2 week wait (2ww) criteria for referral are able to access advice, support, and treatment as necessary	People living with cancer will receive person centred care	Goal 2 – Increase early identification and intervention	Early Diagnosis Rates for Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** Oct 22
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	People living with cancer will receive person centred care	N/A	Early Diagnosis Rates for Cancer	N/A	**Start date:** June 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		undergo and that patients maintain a healthy lifestyle after treatment. This will help to ensure that as many treatments as possible are successful					
CAN10	Person Centred Care – 2 week wait (2ww) 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.	People living with cancer will receive person centred care	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Meet the cancer faster diagnosis standard by March 2024 Cancer - 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 & Neck, Gynae, Prostate, Bladder, Lung, Skin, Colorectal, Upper GI, Pancreas	People will receive the safest and most effective cancer treatments that are available	N/A	Early Diagnosis Rates for Cancer	Meet the cancer faster diagnosis standard by March 2024 Cancer - Continue to reduce the number of patients waiting over 62 days Increase the percentage of cancers diagnosed at stages 1 and 2	**Start date:** Across 2023

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Implementation Plan 23/24 Children and Young People

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
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 7 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.	Children are safe from harm	Goal 2 – Increase early identification and intervention	We will increase the years of life that people live in good health Halt the trend in childhood obesity	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 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.	Children in Leeds are healthy	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	We will increase the years of life that people live in good health	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** April 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		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.					
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: - Role 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	Children are happy and have fun	Goal 2 – Increase early identification and intervention	We will increase the years of life that people live in good health	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 Continue to address health inequalities and deliver on the Core20PLUS5 approach	**Start date:** From 2020 – 2023 (multiple projects)

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Implementation Plan 23/24 End of Life

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
EoL1	Advanced Care Planning (ACP). End of Life	- Launch of new public ACP guide with Public Health 'What if Things Change'. - Full review of system wide ACP training	People approaching the end of their life are recognised and supported on time 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	Goal 2 – Increase early identification and intervention	N/A	N/A	**Start date:** April 2023
EoL2	Early Identification - End of Life – 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.	People approaching the end of their life are recognised and supported on time	Goal 2 – Increase early identification and intervention	N/A	N/A	**Start date:** Q4 23/24
EoL3	End of Life Education Programme	Clinical educator funded for 12 months by the Leeds Palliative Care Network to train 2,000 clinical support workers.	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.	Goal 1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	N/A	**Start date:** June 2023

Leeds Health & Care Partnership

Implementation Plan 23/24 Frailty

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
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	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	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	N/A	**Start date:** Oct – Dec 2023
FR2	Proactive care - Restore 2 & stumble training	Training for care home staff in soft signs of deterioration and falls management	Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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	Identifying and supporting all people in this population group and assessing their needs and assets, as an individual and as a carer	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	N/A	**Start date:** June 2023

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Implementation Plan 23/24 Home First Programme – linked to Frailty Board

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
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 or crisis response) – 2-hour element Emergency Cover for Carers (emergency carer support) Rapid Response to Falls Home Comfort Also includes early intervention – how we reduce avoidable admissions and attendances at hospital.	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) 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 2024/25	**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 & National Housing Trust (NHT) services Expanding the offer of these combined services to support more people at home	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce adult general and acute (G&A) 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 2024/25	**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 CCB to reduce length of stay Designing the model for and recommissioning the rehab and recovery beds in Leeds to a reduced number	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce adult general and acute (G&A) 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 2024/25	**Start date:** May 2023
HF4	Transfers of Care - streamlining our transfers of care between acute and intermediate care services to reduce	As per workstream title, final details in development	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce adult general and acute (G&A) bed occupancy to 92% or below Improve A&E waiting times so that no less than 76% of patients	**Start date:** May 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
	the non-value-added time					are seen within 4 hours by March 2024 with further improvement in 2024/25	

Implementation Plan 23/24 Healthy Adults

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
HA1	System Flow Health Inclusion - Out of Hospital Project for those with no fixed abode / multiple complex disadvantages	This workstream has several parts: A) defined service spec for matrix transfer of care teams for vulnerable adults B) Development work on scaling up 9 temporary housing unit beds as part of current out of hour project, what does good look like? What could excellent look like? C) Emerging work on those on prison release pathways who end up in LYPFT shortly after release	People in Leeds live well, and have a standard of living which supports their health and wellbeing	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Increase the years of life that people live in good health	Reduce adult general and acute (G&A) bed occupancy to 92% or below Continue to address health inequalities and deliver on the Core20PLUS5 approach	**Start date:** New Housing Workers in Transition of Care – July 2023
HA2	Women's Health – Healthy Adults	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	People in Leeds will be physically healthy	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Increase the years of life that people live in good health	Maternity - 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:** TBC

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
HA3	Community Strengths – Local Care Partnership (LCP) community grants, Social Prescribing (SP) community of practice, digital health hubs.	- Community Grants Scheme: 8 LCP 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 non-clinical health and wellbeing needs, and to connect with services to address WDH - 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	People in Leeds will be mentally and physically healthier for longer and where needed, supported to live well.	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Increase the years of life that people live in good health	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:** LCP Grants – March 23 Social Prescribing – March 23 SP Community of Practice – TBC Digital Health Hubs – March 23
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 & 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	People in Leeds will be mentally and physically healthier for longer and where needed, supported to live well.	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Increase the years of life that people live in good health	Continue to address health inequalities and deliver on the Core20PLUS5 approach Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024	**Start date:** - SP in A&E - March 23 Home Plus - March 23 Unplanned care for HA - October 23

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		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).					

Implementation Plan 23/24 Long Term Conditions

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
LTC1	Multimorbidity (3 Long Term Conditions (LTC) Plus Mental Health) -	Digital - remote monitoring implementation for 3 plus LTCs and mental health	People with a LTC take an active role in managing and improving their condition and the prevention of future multi-morbidities	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** September 23
LTC2	Multimorbidity (3 Long Term Conditions Plus Mental Health)) - Long Covid review and rehabilitation model development	Long Covid review and rehabilitation model development	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 3 Primary Care Networks Expansion of pulmonary rehab Spirometry next steps	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** January 23
LTC4	Multimorbidity (3 Long Term Conditions (LTC) Plus Mental Health) -	Conclude local diabetes remission pilot (learnings blend with Integrated weight management model)	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across	N/A	Reduce unnecessary GP appointments and improve patient experience by	**Start date:** - January 22

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
	delivery of Diabetes Steering Group Work	Facilitation of NHS Diabetes Prevention Programme (NDPP) referrals Treatment and care implementation and continuous glucose monitoring implementation		health settings through a focus on keeping people well		streamlining direct access and setting up local pathways for direct referrals	
LTC5	Multimorbidity (3 Long Term Conditions Plus Mental Health)) - delivery of cardiovascular disease (CVD) Steering Group Work	Coordination of hypertension and lipids work Heart failure work exit Anticoagulation next steps	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024	**Start date:** - January 22
LTC6	Multimorbidity (3 Long Term Conditions 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	I'm as healthy and as well as I can be with my LTCs	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	N/A	**Start date:** October 22
LTC7	Lipids - Innovation for Healthcare Inequalities Programme (InHIP) project delivery	West Yorkshire/Academic Health Science Network funded Health Inequalities project	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	**Start date:** July 23
LTC8	Lipids – System Transformation Fund Project Lipids	Project delivery on behalf of West Yorkshire and Leeds	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	**Start date:** July 23
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	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid	**Start date:** July 23

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
						lowering therapies to 60%	
LTC10	Integrated Weight Management	Options appraisal if Integrated Weight Management is not supported	People with a LTC take an active role in managing and improving their condition and the prevention of future multi-morbidities	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	**Start date:** July 23

Implementation Plan 23/24 Maternity

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
M1	MNVP (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	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	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - 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	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	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	**Start date:** May 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
			People are prepared for parenthood				
M3	Doula's	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 though their logic models have identified this as a key priority to ensure "people received personalised maternity care safely"	Families and babies are supported to achieve optimum physical health.	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - 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).	People receive personalised maternity care safely People receive the support they need to improve or maintain their emotional wellbeing	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Achieve a 50% reduction in stillbirths, neonatal deaths, brain injuries and a reduction in maternal morbidity and mortality by 2025	Maternity - 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

Leeds Health & Care Partnership

Implementation Plan 23/24 Mental Health

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
MH1	Community Mental Health Transformation - Mobilisation of new integrated model of care for community mental health with Local Care Partnerships (LCPs) and Primary Care Networks (PCNs)	Piloting and testing of newly designed multiagency integrated MH hub model in 3 local care partnership areas (4 PCNs) ahead of phased roll out across all LCP/PCNs in Leeds	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	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 2022
MH2	Community Mental Health Transformation – psychological therapies	Developing and increasing capacity in psychological therapies for people with SMI and more complex needs	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	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 3rd sector	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	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 in 22/23 and progressing to full delivery within new model of care from Q2 23/24.
MH4	Improving Access to Psychological Therapy (IAPT)	Working to reduce waiting times to access NHS Talking Therapies	People's quality of life will be improved by timely access to appropriate mental health information, support and services	N/A	Reduce the gap in life expectancy for people with Mental Health Conditions	Increase the number of adults and older adults accessing IAPT treatment	**Start date:** 2022/23, in progress
MH5	Mental Health Crisis - Review and evaluation of Mental	Undertaking a deep dive analysis of value and outcomes being delivered in	People's quality of life will be improved by timely access to	N/A	Reduce the gap in life expectancy for people	Work towards eliminating inappropriate adult	**Start date:** June 23

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
	Health crisis provision and models of crisis alternatives	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.	appropriate mental health information, support and services		with Mental Health Conditions	acute out of area placements	
MH6	Community Mental Health Transformation - Physical Health Severe Mental Illness (SMI)	Further develop outreach and pathways improve access to physical health checks and interventions for people with SMI	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Reduce the gap in life expectancy for people with Mental Health Conditions	N/A	**Start date:** Q4 22/23 testing outreach models in early implementer sites for new model of care
MH7	Community Mental 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.	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	Reduce the gap in life expectancy for people with Mental Health Conditions	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 22/23 for recruitment-recurrent investment for delivery from 1 April 23)
MH8	Mental Health Crisis – Street Triage	Implementation and evaluation of new delivery model for Street Triage	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	Reduce the gap in life expectancy for people with Mental Health Conditions	Work towards eliminating inappropriate adult acute out of area placements	**Start date:** Redesigned model implementation commenced April 2023

Leeds Health & Care Partnership

Implementation Plan 23/24 Planned Care

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
PC1	Earlier Diagnosis - Community Diagnostic Centres (CDC)	Business case approved to develop 3 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.	Planned Care services are accessible to all regardless of who they are	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	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:** Implementation underway across all 3 x sites, to be delivering additional diagnostic activity by Q2 2023/24. Business Case for 23/24 & 24/25 submission due June 2023
PC2	Earlier diagnosis - LTHT 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	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	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 Service (CUES)	Service established August 2020 during Covid, 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	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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	**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.

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		and A&E services (to a lesser degree)				further improvement in 2024/25	
PC4	Managing Capacity and Elective Recovery – Ear, Nose and Throat (ENT) 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	Planned Care services are accessible to all regardless of who they are	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) 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	Planned Care services are accessible to all regardless of who they are People are supported whilst waiting for planned care services	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) 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)	N/A	N/A	N/A	N/A	**Start date:** September 2023
PC7	Managing Capacity and Elective Recovery - LTHT Transformation Programme - Planned Care	Multiple projects: - Theatre Productivity - Day Case - Patient optimisation - Reducing non-elective pressures	N/A	N/A	N/A	N/A	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		- BADS					
PC8	Manging Capacity and Elective Recovery - Ophthalmology Re-procurement	Re-procurement of community-based ophthalmology services – Any Qualified Provider (AQP) window to be re-opened 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	People are supported whilst waiting for planned care services Planned Care services are accessible to all regardless of who they are	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) 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	Outpatients 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.	People are supported whilst waiting for planned care services	N/A	N/A	Elective activity levels as a proportion of 19/20 activity reaching 108%	**Start date:** In progress
PC10	Outpatients (OP) 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	People are supported whilst waiting for planned care services	N/A	N/A	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 specialties)	**Start date:** In progress
PC11	Outpatients Redesign - Reduction in outpatient follow up (OPFU)	Supporting LTHT project team in developing and delivering phased reduction in OPFU activity by 25% (compared to 19/20	People are supported whilst waiting for planned care services	N/A	N/A	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties	**Start date:** February 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		activity), through programme of Clinical Service Unit targeted benchmarking, identification of opportunities, and implementation.				Elective activity levels as a proportion of 19/20 activity reaching 108%	
PC12	Outpatients Redesign - LTHT 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	N/A	N/A	N/A	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. 4 x 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/ Crossgates/ Middleton & Hunslet and	People are supported whilst waiting for all planned care services People agree appropriate and realistic shared health goals, and actively participate in their achievement	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 specialties)	**Start date:** April 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		Burmantofts/ Harehills and Richmond Hill.					

Implementation Plan 23/24 Primary Care

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
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.	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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)	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.	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 on 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 LD	Focus on those patients who have not received an annual health check in previous 18 months (Quality Improvement Scheme)	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and / or autism	Ensure 75% of people aged 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	N/A	2 - Increase early identification and intervention (of both risk	N/A	Recover the dementia diagnosis rate to 66.7%	**Start date:** April 2023

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
		of dementia and offer assessment and referral (Quality Improvement Scheme)		factors and actual physical and mental illness)			
PRI5	Increasing the primary care workforce	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	N/A	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 Continue on 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	N/A	2 - Increase early identification and intervention (of both risk factors and actual physical and mental illness)	N/A	N/A	**Start date:** N/A

Implementation Plan 23/24 Same Day Response

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
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	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane day needs People's same day care needs are met wherever they present (if possible), and where they need to	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 2024/25 Reduce adult general and acute (G&A) bed occupancy to 92% or below	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
			be cared for elsewhere, this feels seamless and integrated				
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	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane 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	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 2024/25 Reduce adult general and acute (G&A) bed occupancy to 92% or below	**Start date:** December 2022
SDR3	Same Day Response (reducing people attending A&E) - Maximise PCAL	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	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane 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	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 2024/25	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
SDR4	Same Day Response (reducing people attending A&E) – Developing Same Day Emergency Care (SDEC)	Same Day Emergency Care (SDEC) aims to reduce admissions and ED attendances by providing timely assessment, diagnosis and treatment, improving patient experience and care.	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	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 2024/25 Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	**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 - 2-Hour Crisis Response offer, Telecare Rapid Falls Response • Virtual Wards (Hospital	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane day needs People's same day care needs are met wherever they present (if possible), and where they need to be cared for	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 2024/25 Reduce adult general and acute (G&A) bed occupancy to 92% or below Consistently meet or exceed the 70% 2-hour urgent	**Start date:** In progress

No	Workstream / Project	Description	Related Population Outcome	Impact on Place Goals	Impact on West Yorkshire 10 Ambitions	Impact on NHS National Objective	Timescales for Implementation
			elsewhere, this feels seamless and integrated			community response (UCR) standard	
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.	People are easily able to access the service that can provide the most responsive and appropriate care to meet their unplanned sane 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	1 - Reduce avoidable unplanned care utilisation across health settings through a focus on keeping people well	N/A	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 2024/25	**Start date:** In progress