The Healthy Leeds Plan

2023 - 2028

Summary Document

Introduction

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.'

The [Healthy Leeds Plan](#) sets out the health and care contribution towards achieving this vision. The plan outlines our five-year strategic vision and focuses on equitable access, excellent experience, and optimal outcomes for people living in Leeds, ensuring we get the best value from the Leeds pound.

The Leeds Health and Care Partnership (see the image below) 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 are an inclusive partnership, starting with people and bringing together a network of statutory and non-statutory third sector, health, local government, academic and industry partners.

Fig 1: The Health and Care Partnership in Leeds

We also have a role beyond the boundaries of the city, by delivering services regionally and as a key partner within the [West Yorkshire Health and Care Partnership](#) alongside the four other 'places' in West Yorkshire (Bradford District and Craven, Calderdale, Kirklees, and Wakefield District).

Leeds Health & Care Partnership

The principles of our Health and Care Partnership underpin how we work together to deliver on our ambition and vision:

We start with people:

Working with people in Leeds, communities, paid and unpaid carers, and our workforce.

We are Team Leeds:
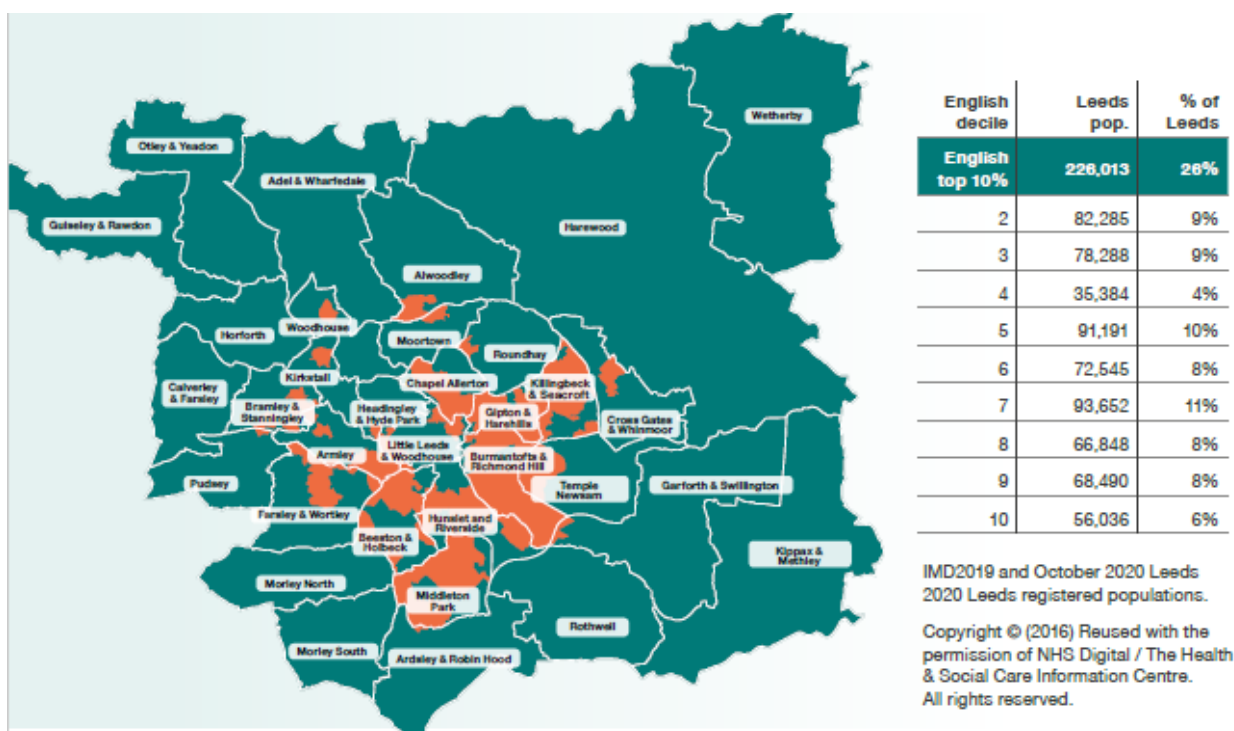
Working together as if we are one organisation.

We deliver:

Ensuring every action improves outcomes and quality and makes the best use of the Leeds pound.

Understanding our population

Within Leeds, not everyone 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, which is an estimated 226,000 people, are living within the 10% most deprived areas nationally (or IMD 1, the lowest decile in the national Index of Multiple Deprivation).

The image below shows a map 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.

We know that health and wellbeing is affected by the wider determinants of health 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. Our Joint Strategic Assessment provided strong evidence that some inequalities are widening and will worsen following the COVID-19 pandemic.

- Our population is growing, specifically within inner-city areas which are often our most deprived communities who 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 our most and least affluent areas.
  - Whilst people are living longer this is often in poorer health and with multiple long-term conditions
  - 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 child population is also growing faster than that of the population of Leeds as a whole and is concentrated within the secondary school-age groups, and within communities most likely to experience deprivation.
- 34% of children and young people in Leeds live in the 10% most deprived areas nationally.
- Our most deprived areas are more ethnically diverse than the Leeds average.

All these factors, and more, have implications for service provision, and Leeds faces a number of significant challenges. The COVID-19 pandemic has driven up demand for health services in most areas above that which we saw before the pandemic 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.

Our approach to addressing these challenges

To meet our citywide vision, given these challenges, we must start to understand and respond to future population needs 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 partnership, to focus our collective efforts toward a few specific goals to really drive change for the people of Leeds. 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 focussing on what matters to people.
2. The population's health overall will move from being sicker and more dependent on services, to **living, ageing, and dying well**.
3. For the population health to improve equitably and for us to reduce health inequalities, our partnership will need to ensure services are **more inclusive and better targeted.**
4. To achieve our ambition, we will need to shift more resources into **prevention and personalised, proactive care**

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:

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

Preventable unplanned utilisation refers to access or admissions to services where there was scope for earlier or different action to prevent an individual's health or wellbeing deteriorating 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, families and staff have told us is important to them.

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

Better outcomes for people: people have told us that they would prefer access to care in a planned way rather than unplanned. Data indicates 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 a considerable amount of financial and operational resource is utilised by unplanned care.

Addressing health inequalities: those living in the most deprived areas are more likely to utilise healthcare in an unplanned way. We also know the number of people living within IMD1 (the most deprived in our population) is expected to grow the fastest in the future.

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 2 and its supporting measures will be developed at a later stage during 2023/24.

Our strategic initiatives

Measurable improvement towards 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 to identify, design and implement interventions and service changes that will have the biggest impact in people's health and wellbeing.

Following identification of our strategic 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). The LDM is our pseudonymised, person level, linked data set bringing together data from a range of partner organisations delivering health and care to the people of Leeds.

Using data from the most recent financial year (2022 / 2023) and focusing on unplanned emergency admissions to acute services 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 further to identify themes and potential relationships to population segments. This methodology was an iterative process and tested with clinicians and subject matter experts at each stage.

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

Children and young people population: Diseases of the respiratory system

The data analysis identified that a significant number of children and young people and their families were impacted by respiratory disease, with a higher prevalence in areas of deprivation. For people living in areas of deprivation the average length of stay, for non-elective bed days, was 2.5 days longer compared to the Leeds average. Through the work of the Children and

Young People's Population Board, and in developing our health economic approach in Leeds, we know that people under the age of 18 are demonstrating the fastest population growth within IMD 1 areas in Leeds. Therefore, investment in prevention for this population group is important to support them in leading healthy lives in the future.

People with three or more long-term conditions and serious mental illness

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

Serious mental illness and multiple long-term conditions are plus groups, as defined within the national Core20PLUS5 Programme. Three of the five clinical areas identified within the Core20PLUS5 programme that require accelerated improvements are workstreams within the serious mental illness population board and the long-term conditions population board.

## Frailty, and cancer populations: Injury / fracture

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

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

End-of-life population: Diseases of the respiratory system

The end-of-life population segment is our smallest population segment in size but represents the fourth highest number of bed days in total with the highest rate of bed days per 1,000 population. The rate of bed days per 1,000 population is higher for the people living within the more deprived areas of Leeds. With the projected growth in the population of Leeds who are over 80 years it is important that we understand and address this utilisation. This strategic initiative will be taken forward through the end-of-life population board with input from the long-term conditions and frailty population boards.
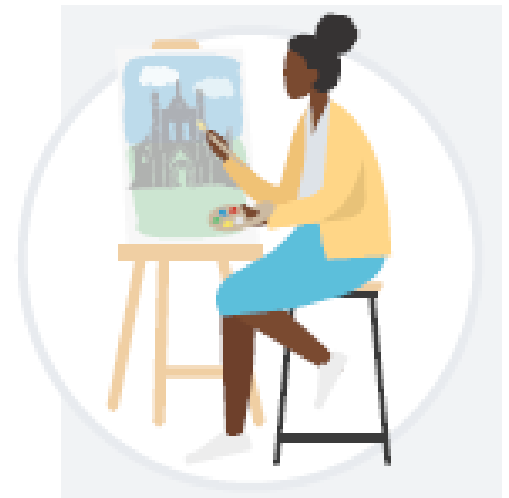
Intermediate care provision: HomeFirst programme

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

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

The HomeFirst Programme represents our fifth strategic initiative for the partnership. This programme is developing and implementing a new model of intermediate care services to address the challenges described above, achieving more independent and safe outcomes for people, unpaid carers and staff.

By delivering improvements in five project areas (active recovery at home, enhanced care at home, rehab and recovery beds, transfers of care and system visibility, and active leadership) it is expected to create real change for the people of Leeds, within measurable improvements in the following areas:

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

Through the initial work of the HomeFirst programme, we know that 30% of the most deprived areas within Leeds account for 42% of intermediate care patients. On average, those patients living in IMD 1 are typically more frail and younger than the users living within other areas.

People living with dementia are at least twice as likely to access intermediate care as the average person over 80 years or the frailty population. Patients living with dementia have a higher re-admittance rate to hospital following discharge from the Neighbourhood Teams or Community Care beds. We also know that in Leeds people living with dementia have a disproportionate use of unplanned utilisation, particularly non-elective bed days and this is higher for those people living in IMD 1.

Summary and Next Steps

Our Healthy Leeds Plan sets out the health and care contribution towards achieving the vision of our Health and Wellbeing Strategy. This work will be driven through our Leeds Health and Care Partnership.

We will work to improve outcomes for the people of Leeds, their experience of health and care services and the use of the Leeds pound through our two shared system goals. We will focus on the 26% of the population who live in the 10% most deprived areas nationally. Our shared goals are:

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

To meet these goals, 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 such as digital, estates, workforce, quality improvement and research.

Our strategic initiatives will continue to develop as our data capabilities become increasingly sophisticated supporting us to identify need and intervene earlier to prevent poor outcomes for the people of Leeds.

Find out more
Please refer to the full version of the Healthy Leeds Plan for further information, which is also available in a plain text. An easy read version of this document is available on the Leeds Health and Care Partnership website.

If you have any questions, please get in touch by emailing wyicb-leeds.comms@nhs.net or call 0113 221 7777.