Leeds Health & Care Partnership

Neighbourhood Proactive Care in Leeds

Helping people live well, stay independent, and thrive in their communities.

Healthcare in Leeds is changing. Instead of reacting to illness as it happens, we're acting earlier to keep people well. This isn't just a process change, it's a cultural shift. We're:

- **Breaking down barriers between health, care, and community.**
- **Putting people first, focusing on what matters most to them.**
- **Working as one team, united across services.**
- **Prioritising prevention and early support, not just crisis response.**
- **Tackling inequalities, so care is fair for everyone.**
- **Empowering staff and valuing relationships, because great care starts with people.**

This document is for leaders, teams and services implementing Neighbourhood Proactive Care (NPC). Its purpose is to help you share the vision and approach to NPC with colleagues, so you can discuss and agree the role of your team, and the actions needed to play your part in delivering proactive care effectively. The document sets out:

- Why NPC is a priority for Leeds.
- What benefits it brings to local people.
- The framework and principles guiding implementation.
- What will be delivered consistently across all neighbourhoods.
- What can be adapted locally to meet specific needs.

1: WHY IS PROACTIVE CARE A PRIORITY?

What the data tells us...

In Leeds, we have a growing and aging population, with the 80 to 84 year old population expected to increase by 27% by 2030.

More people are living with multiple long-term conditions (LTCs), with 17% of the over-65 population expected to be living with 4 or more LTCs by 2035.

Resources are stretched because we need to support more people who have a greater number of needs.

The population identified for Proactive Care makes up just 5% of the total Leeds population, but they account for:

50% of unplanned bed days. **19%** of outpatient appointments. **80%** of social care packages.

These trends are worse for people in the poorest parts of the city.

Proactive Care for this population will improve their health, and reduce demand for unplanned care.

#TeamLeeds

What people tell us...

We are a system that starts with people. We listen to what is important to them, and design services and support that meets their needs. People have continually told us of the three things that should change, that would improve their experiences of care:

- Communication - clear information, shared once.
- Compassion - care delivered with empathy.
- Co-ordination - joined-up services, no duplication.

These are known as the 3Cs, and health and care leaders are committed to putting them at the centre of all health and care. Embedding Neighbourhood Proactive Care will enable more coordinated local services, improved communications between patients, carers, and health staff, and compassionate services tailored to the needs of individuals.

Other things that people have told us are important to them, include:

- Person-centred care: People want care tailored to their individual needs.
- Time to talk: People want enough time in appointments to discuss all their health conditions.
- Involvement: People and carers want to be fully involved in decisions.
- Tell their story once: People want to share their story and have health and care staff work together with clear and respectful language.
- Resources & Information: People and carers want access to information and resources that help them manage their health and wellbeing.
- Good Housing & Activities: People want good housing, social activities, exercise opportunities, and safe transport.
- Health Inequalities: People want fair and equal access to services for everyone, no matter their age, background, identity, or where they live.
- Independence at home: Living at home with dignity for as long as possible.
- Respectful workforce: Staff who understand and respect people's needs.
- Environment and safety: Help to prevent falls and support for visual impairments.
- Carer support: Carers want flexibility, freedom, and access to respite care so they can balance caring with their own lives.

Through NPC we can help make a change for local people, providing services that work for them, and help them to stay healthier for longer.

1.3 - Supporting Neighbourhood Health

Neighbourhood Proactive Care is a vital component of Leeds' journey towards Neighbourhood Health, but it represents just one part of the wider approach.

Proactive Care focuses on a targeted model - identifying individuals most at risk of a health crisis and intervening early. Neighbourhood Health takes a broader, community-based perspective, aiming to improve health and wellbeing for everyone within a neighbourhood.

Both share common values: delivering care locally, prioritising prevention and early intervention, integrating services, reducing health inequalities, empowering communities, and promoting a holistic view of health. The key difference lies in scope: Neighbourhood Health is population-wide, while Neighbourhood Proactive Care concentrates on those at greatest risk.

The work delivered through the Neighbourhood Proactive Care Programme strengthens Neighbourhood Health in Leeds, and likewise, initiatives being delivered to embed Neighbourhood Health (such as the National Neighbourhood Health Implementation Programme) support the success of Neighbourhood Proactive Care.

1.4 - Supporting our Leeds HomeFirst vision

The Neighbourhood Proactive Care Programme delivers phase two of the Leeds HomeFirst Programme:

Our vision:
"In partnership with local people, neighbourhood health and care services will work together to proactively prevent health and wellbeing deterioration, ensuring more people can live independently and be supported in their own homes."

The Leeds HomeFirst Programme has already delivered significant achievements:

- Transformed intermediate care services.
- Reduced hospital admissions and length of stay.
- Enabled more home and community-based care.

In this next phase of the programme, we are focussing on prevention before crisis, shifting action upstream to prevent health deterioration before people reach crisis point and need unplanned care. This means the programme is now taking a dual approach:

1. Preventing crises through Neighbourhood Proactive Care interventions.
2. Improving response with better coordinated intermediate care services when unplanned care is needed.

By working proactively with people and communities, we can prevent health crises and reduce reliance on unplanned care—while ensuring those who do need support can access high-quality, coordinated care at home or in the community.

2: WHAT DIFFERENCE WILL PROACTIVE CARE MAKE TO PEOPLE?

Proactive care enables positive change by shifting from reactive crisis response to early prevention. Rather than helping people cope with illness, we connect them, and their carers, to the right support at the right time, helping them stay well, independent, and connected to their communities. This approach targets those most at risk of unplanned care, slowing the progression of multiple long-term conditions and frailty.

Who we support:

Neighbourhood Proactive Care targets people living with multiple long-term conditions or frailty, and their carers. Most are over 75, though some are working age. Many live with moderate to severe frailty. Evidence shows that people in the most deprived areas develop multiple long-term conditions 10-15 years earlier, are twice as likely to experience frailty, and spend longer living with frailty and poor health compared to those in less deprived areas.

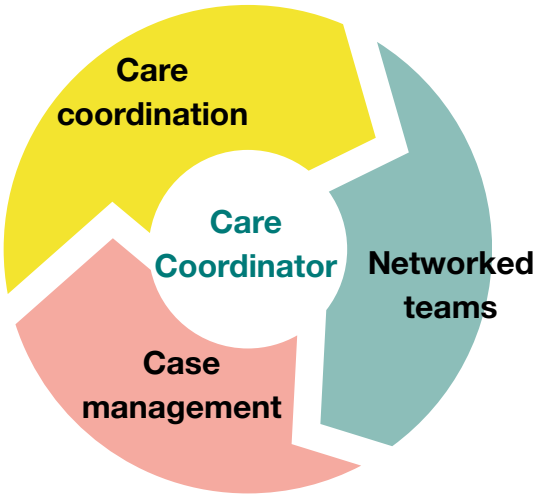
How we help:

By supporting people to manage their conditions well, we can prevent the onset of frailty or slow its progression. Proactive care uses a multi-agency approach, identifying and supporting people and their carers before they reach crisis point.

- Early identification and intervention keeps individuals well, independent and connected to their communities for as long as possible
- Support centres on what matters to the person and aims to give people choice and control over how their care is planned and delivered

Care Coordination is at the heart:

Care Coordination considers the holistic needs of the person and their carer, bringing together the right services to help them achieve their goals. It reduces duplication and unwanted interventions by focusing on what matters most to the person and their carer.



The Care Coordinator:

Every neighbourhood has at least one Care Coordinator, a trusted person who acts as a single point of contact and coordinates overall care.

Care Coordinators have access to a 'multi-agency networked team' when additional support is needed. They know exactly who to contact and how to reach them quickly.

When more intensive support is required, Care Coordinators may arrange Case Management or Multi Disciplinary Team (MDT) meetings.

Care and Support Plan

People receiving Neighbourhood Proactive Care have a holistic assessment, identifying their personal goals and the support needed to achieve them. They then receive tailored interventions through a Personalised Care and Support Plan—ranging from clinical support (e.g., specialist services) to practical help (e.g., financial support for carers).

Case study: Advanced respiratory

Through the Advanced Respiratory Project, Cross Gates and Seacroft Local Care Partnerships have been supporting people who live with severe frailty and respiratory disease. Each person is supported by a Care Coordinator and Community Matron who coordinate a network of providers, drawing on specific expertise as needed.

Support has included:

- Additional community respiratory team input.
- Support for carers.
- Non-medical interventions, for example arranging local cleaners.
- Access to advice through a support line, led by Telecare at Leeds City Council, in partnership with the Yorkshire Ambulance Service.

(Video Plays on YouTube: https://www.youtube.com/watch?v=mxg76dC9TgU)

Debra's husband John is benefitting from this project

"They have been coming quite regularly and when they come they engage with John and actually listen to what John says. So rather than a doctor who would come in and diagnose they actually spend time listening to John's version of events. Its more holistic. They may come to just ask him about his chest but then they ask about other aspects so there is an overall concern and interest in his whole condition rather than just one specific aspect of it. I really like that they can get us in touch with other departments quite quickly. So for instance if John needs other breathing assistance they are the conduit to get us in touch with the right people there."

Beryl, 90, is benefitting from advanced respiratory proactive care

"I've got a nurse come to see me regularly and she is great. She got me on oxygen that I can't thank her enough for because I've been great since I've had it at home. I like it because it's the same people who come to see me, and they have done so much for me, and I feel better when I know that somebody is coming to look after me and see if I need anything".

How will people, carers and staff feel about their care?

A description of what we hope people, carers and staff will be saying as we increasingly adopt proactive care as a system can be seen in the I statements below:

People	Carers	Staff
I have care and support to help me live as I want to, seeing me as a unique person with skills and strengths.	I feel that what I do as a carer is recognised, understood and valued.	I support people to understand how they can help themselves to achieve their goals.
I have care and support that is coordinated, and everyone works well together.	I am listened to and feel part of the team planning care for the person I care for.	I find work rewarding as it supports people to achieve their goals.
I feel confident that I can balance my health and care needs with my work commitments.	I feel that I am supported to look after my own health and wellbeing.	I have the right mix of people around me to support me in keeping people well.
I feel confident I can remain in my own home for longer and can join in community life, which is important to me.	I feel confident in supporting the person I care for to stay well.	I have a manageable workload.
I am involved in decisions about my health and care and feel in control.	I can get information and advice that is accurate, up to date and provided in a way that I can understand.	I am encouraged to share my experience and skills.
I can get information and advice that is accurate, up to date and provided in a way that I can understand.		I would recommend working in Leeds to other people.

3: A FRAMEWORK FOR IMPLEMENTING PROACTIVE CARE

3.1 - Principles of Neighbourhood Proactive Care

Our shared principles should be kept in mind when coming together to make decisions:

- Focus on the holistic needs of the person and their carers.
- Work as Team Leeds.
- Make doing the right thing the easiest thing.
- Data and evidence led.
- Shared and agreed goals.
- Clear, simple pathways.
- Clear communication.
- Resources follow need.
- Encourage innovation.

3.2 - What do we commit to delivering once city-wide and what should be flexed to meet local demand?

Partners in Leeds have agreed that our Neighbourhood Proactive Care model should combine flexibility with a clear framework. Where consistency is essential across the city, we will adopt universal approaches. Where local adaptation is needed, neighbourhoods will have the flexibility to tailor solutions. This means:

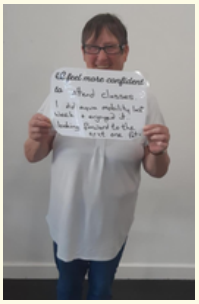
- All neighbourhoods work towards the same citywide principles (see above), but they are deployed flexibly for local need.
- The priority population for all neighbourhoods is local people at greatest risk of unplanned care. Supporting tools will be developed centrally, and deployed at neighbourhood level to identify specific individuals.
- Personalised Care Plans are created using standardised digital tools across the city.
- Core central team with flexibility in neighourhoods to respond to local needs.
- One citywide evaluation framework, with data collated at neighbourhood level.
- Citywide communications materials that can be adapted for local need.
- One citywide training programme taken-up locally based on needs.

Case study: Falls prevention

Falls hubs have opened in Armley and York Road PCNs, aimed at people living with mild to moderate frailty who are at risk of a fall. People benefit from strength and balance classes in addition to a range of other support.

The hubs also aim to address social isolation through providing lunch, and provide transport to support people who otherwise wouldn't have been able to get there. As a result of this work, more people from these areas are being referred into falls prevention services such as Care and Repair

P and W are among those who attended the Falls Hub taster day together and signed up to classes, including Strength and Balance, Tea and Toast, and Active Leeds Aqua Mobility sessions. They have also engaged with Linking Leeds, and have both reported feeling more confident and of making new friends in the classes.



P said: "I feel more confident to attend classes. I did aqua mobility last week and enjoyed it... looking forward to the next one."

W said: "I feel more confident to bend and pick things up from the floor."

Photos courtesy of Active Leeds

3.3 - What is a local Proactive Care Networked Team and who is in it?

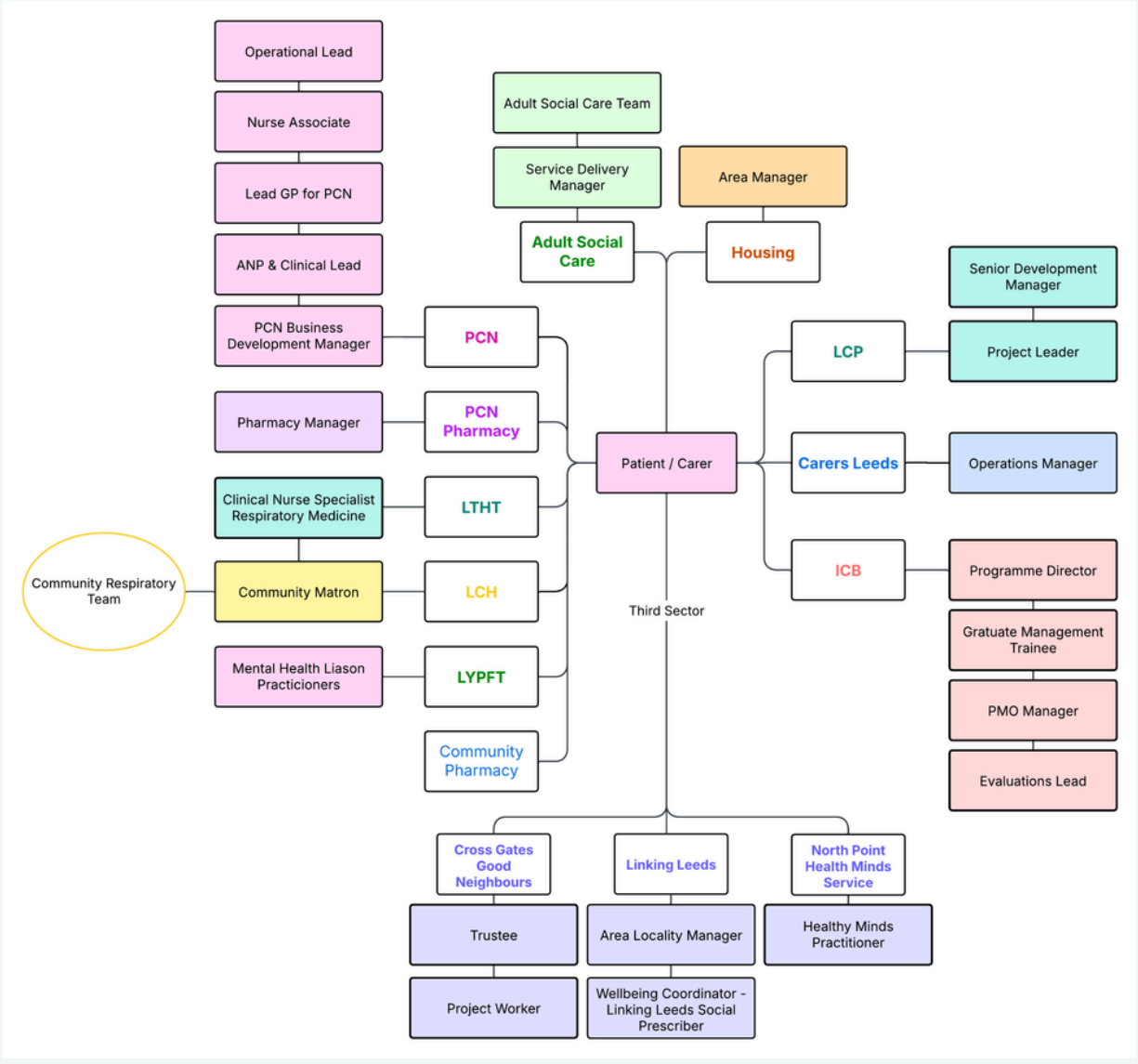
Every Primary Care Network (PCN) and Local Care Partnership (LCP) will have a dedicated Proactive Care core team - made up of the Care Coordinator, Community Matron, and key PCN staff - focused on managing care effectively.

Around this core sits a multi-agency network, bringing together partners from statutory and non-statutory organisations. These teams don't just tackle healthcare - they address the wider determinants of health to support people and their carers holistically.

The goal? Strong, seamless relationships. The core team can tap into networked partners whenever needed—no waiting for scheduled meetings—so individuals get the right care at the right time. Together, these teams will innovate and collaborate to manage populations proactively.

Some PCNs and LCPs will hold regular meetings with partners who can add value. Others may run non-clinical MDT sessions to focus on broader health factors. Each approach will be tailored to local needs.

Example of a networked team: Cross Gates PCN Advanced Respiratory



All local health and care partners have a role to play in a local networked team, the role they play will need to be determined by the needs of the target community, but could include:

Adult Social Care	• Neighbourhood Team Worker linking in to the Multi Agency Networked Team, with other teams, such as the Early Intervention Team, brought in as appropriate. • Telecare providing bespoke support around specific areas.
Leeds Community Healthcare	• District Nurses and Community Matrons delivering proactive person-centred care at home – intervening before crisis occurs – with an emphasis on MDT working.
Leeds Teaching Hospitals Trust	• Linking Geriatricians into each neighbourhood. • Targeted advice and guidance support.
Leeds and York Partnership Foundation Trust	LYPFT's transformation programmes and existing structures enable a proactive approach to care. Delivering services in community settings - such as people's homes and local venues - helps reduce reliance on crisis escalation and promotes continuity of support. Work is ongoing to strengthen connections with primary care, council services, and the VCSE sector to enhance mental health support within communities. Dementia Mental Health Practitioners (DMHLPs) work closely with neighbourhood-focused structures, aligning with the Leeds Proactive Care agenda for identified populations. Other Older Age Mental Health community services also contribute to this approach. The approach to linking in with the working age adults element of the work is in development.
Primary Care	Leads the implementation of Proactive Care at the neighbourhood level. Catalyst for agreeing working relationships with partners and maintaining strong relationships. Aligns local general practice resource around the population to provide care co-ordination, medical input and pharmacy support. Use their data sets and long term relationships to identify and approach people for support.
Public Health	• Links into public health training offer for the proactive care workforce. • Seeks to maximise role of PH commissioned services such as smoking cessation, Home Plus, NHS Health Checks, drug and alcohol, community facing services
Third Sector	• Focus on the social determinants of health' and reaches into communities with the complex needs / those seldom heard communities. Provides local flexible non-clinical support, helping reduce pressure in primary and secondary care.

4: MEASURING SUCCESS

A system wide approach has been agreed to help us understand collectively what has worked well and what could work even better. The key outcomes that will be used to evaluate success are:

- Primary Care Networks and Local Care Partnerships engage with Neighbourhood Proactive Care and establish networked multi-disciplinary team approaches to the delivery of care.
- Proactive working improves the quality of care and quality of life of the people it supports, their carers and families.
- The staff who deliver proactive care and wider stakeholders, including the third sector, feel that it was implemented effectively and benefits the people they support, their carers and families.
- Proactive care improves the value delivered by the health and care system in Leeds by helping people manage their health more actively and access care in a more structured way.

A more detailed outline of the specific measures that will be used for each outcome is available in the appendices of this document.

GLOSSARY OF TERMS

Care coordination	Care coordination considers the holistic needs of the person and their carer and helps to bring the right services together around them to support them in achieving their goals. It particularly helps people who receive support from a range of services, helping to reduce duplication through focusing on what matters to the person and their carer at that time. A Care Coordinator is someone who builds trust with a person and their carer, acts as a single point of contact and has overall coordination of their care.
Case management	Case Management in the context of Neighbourhood Proactive Care is what happens when a person has a range of needs and requires a conversation with and support from a number of partners from across the health and care system to help them in progressing towards achieving their goals.
HomeFirst Programme	The Leeds HomeFirst Programme is an innovative, city-wide initiative that is prioritising care closer to home and preventing unnecessary hospital admissions. Initially the programme was focussed on intermediate care, with a focus on preventing hospital admissions, and supporting people to be discharged from hospital sooner. The scope of the programme has since been broadened to include neighbourhood proactive care, focussed on preventing people needing unplanned care in the first place.
Intermediate care	Intermediate care refers to short-term, time-limited services designed to help people avoid unnecessary hospital admissions, support early discharge from hospital, and prevent long-term dependency on care services. It acts as a “bridge” between hospital and home or between different levels of care.
Local Care Partnership	A Local Care Partnership (LCP) is a collaborative network designed to bring together health, social care, and community organisations within a defined neighbourhood to improve local care delivery. LCPs differ from PCNs, in that they have a broader scope, bringing together a wider range of partners, enabling them to develop more holistic approaches to improving health and wellbeing. Whilst many LCPs have the same defined footprint as PCNs, there are some differences.

National Neighbourhood Health Implementation Programme	The NNHIP is a large-scale national change programme aiming to bring healthcare closer to communities by creating integrated Neighbourhood Health Teams. These teams combine GPs, nurses, social care, and voluntary sector partners to deliver joined-up, holistic care for people with long-term or complex conditions. The programme focuses on reducing health inequalities, improving access in deprived areas, and shifting care from hospitals to local settings. It aims to empower communities, improve patient outcomes, and make services more efficient by coordinating health and social support at a neighbourhood level. Leeds is one of the 43 pilot sites for this national programme.
Neighbourhood Health	Neighbourhood health refers to a model of delivering integrated, community-based care centred around geographically defined populations—typically 30,000–50,000 people—with the aim of providing proactive, convenient services that keep people well in their own communities. Neighbourhood proactive care is one element of neighbourhood health - but whilst NPC has a clearly defined target audience, neighbourhood health has a wider remit for the whole population.
Neighbourhood Proactive Care	• Proactive care is a multi-agency approach to health and wellbeing that identifies and supports the needs of people and their carers before they reach a point of crisis. • It focuses on early identification and intervention to keep individuals well, independent and connected to their communities for as long as possible. • Support is based around what matters to the person and aims to give people choice and control over the way their care is planned and delivered.
Primary Care Network	A Primary Care Network (PCN) is a collaborative group of general practices (GP surgeries) that work together, along with other health and social care providers, to deliver more integrated and coordinated healthcare services to a local population. They aim to improve access to healthcare, enhance patient outcomes, and reduce pressure on hospitals by providing proactive and personalised care. Typically they cover 30,000 to 50,000 patients.

APPRENDIX 2: EVALUATION FRAMEWORK

EVALUATION OUTCOMES	KEY MEASURES
Primary Care Networks and local care partnerships engage with the proactive care programme and establish networked multi-disciplinary team approaches to the delivery of care for the people in the proactive care cohort.	• Which cohorts have the PCNs and LCPs identified to work with. • Is support provided in a way which supports communities at risk from health inequalities. • Have the PCNs and LCPs established effective multi-disciplinary ways of working. • How are the PCNs and LCPs supporting their cohorts including which services are they referring patients into.
Proactive care improves the quality of care and the quality of life of the people it supports, their carers and families.	• What is the individuals experience of proactive care • What is the experience of carers and the families of those in receipt of proactive care. • People in receipt of proactive care, their carers and families report that the quality of care they receive has improved. • People in receipt of proactive care report that their quality of life is improving.
The staff who deliver the service and wider stakeholders, including the third sector, feel that it was implemented effectively and that it benefits the people they support, their carers and families.	• How well was the programme implemented. • Staff and stakeholders report they can work more efficiently and effectively in a multi-disciplinary environment. • What were the benefits for those in receipt of proactive care, their carers and families of the programme as reported by staff and stakeholders.
Proactive care improves the value delivered by the health and care system in Leeds through supporting people to manage their health more actively and access care in a more structured way.	• People in receipt of proactive care were more confident about managing their care in a more active way. • Progression of frailty recorded using the Electronic Frailty Index is slowed for the population in receipt of proactive care in comparison to a similar control group. • Patients make more use of the wider health and care system in Leeds accessing services from other actors in a proactive way • Patients make more use of the wider health and care system in Leeds accessing services from other actors in a proactive way • An emphasis on more confident patients, receiving better planned care in a more holistic manner results in an improvement in the planning, management and delivery of care, making it better planned, more predictable and less expensive.