Health & Wellbeing Board: 22nd October 2014

Supplementary Information to the Agenda Papers: BCF Leeds Submission

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Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

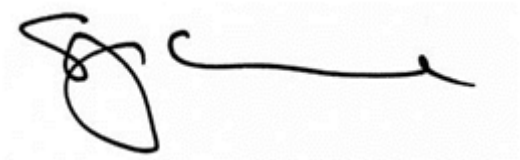
Local Authority	**Leeds City Council**
Clinical Commissioning Groups	**NHS Leeds South and East CCG**
	NHS Leeds West CCG
	NHS Leeds North CCG
Boundary Differences	**None. 3 x CCGs are jointly coterminous with local authority**
Date agreed at Health and Well-Being Board:	**Agreed via email Board meeting 12/9/14**
Date submitted:	**19/9/2014**
Minimum required value of BCF pooled budget: 2014/15	**NIL**
2015/16	**£54.9m**
Total agreed value of pooled budget: 2014/15	**£7.759k**
2015/16	**£54.9m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Leeds South and East CCG
By	 Matt Ward
Position	Chief Operating Officer
Date	**19/9/14**

Signed on behalf of the Clinical Commissioning Group	Leeds North CCG
By	 Nigel Gray
Position	Chief Officer
Date	**19/9/14**

Signed on behalf of the Clinical Commissioning Group	Leeds West CCG
By	 Philomena Corrigan
Position	Chief Officer
Date	**19/9/14**

Signed on behalf of the Council	Leeds City Council
By	 Sandie Keene
Position	Director of Adult Social Services
Date	**19/9/14**

Signed on behalf of the Health and Wellbeing Board	Leeds Health and Wellbeing Board
By Chair of Health and Wellbeing Board	 Councillor Lisa Mulherin
Date	**19/9/14**

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title
Appendix 1 – Leeds £ plan on a page
Appendix 2 – Best City approach to health and social care – executive summary
Appendix 3 - Leeds Integrated Health & Social Care Outcomes Framework
Appendix 4 – results of HealthWatch Leeds public consultation on Leeds' BCF
Appendix 5 – Case study: Patricia's story
Appendix 6 – Integration dashboard
Appendix 7 – Transformation structure diagram
Appendix 8 – Carers Strategy
Appendix 8a - Quick Guide for Carers leaflet Jan 2014 final
Appendix 9 - Charter for involvement
Appendix 10 – 5 year strategy plan on a page
Appendix 11 - Leeds integrated health and social care pioneer bid

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

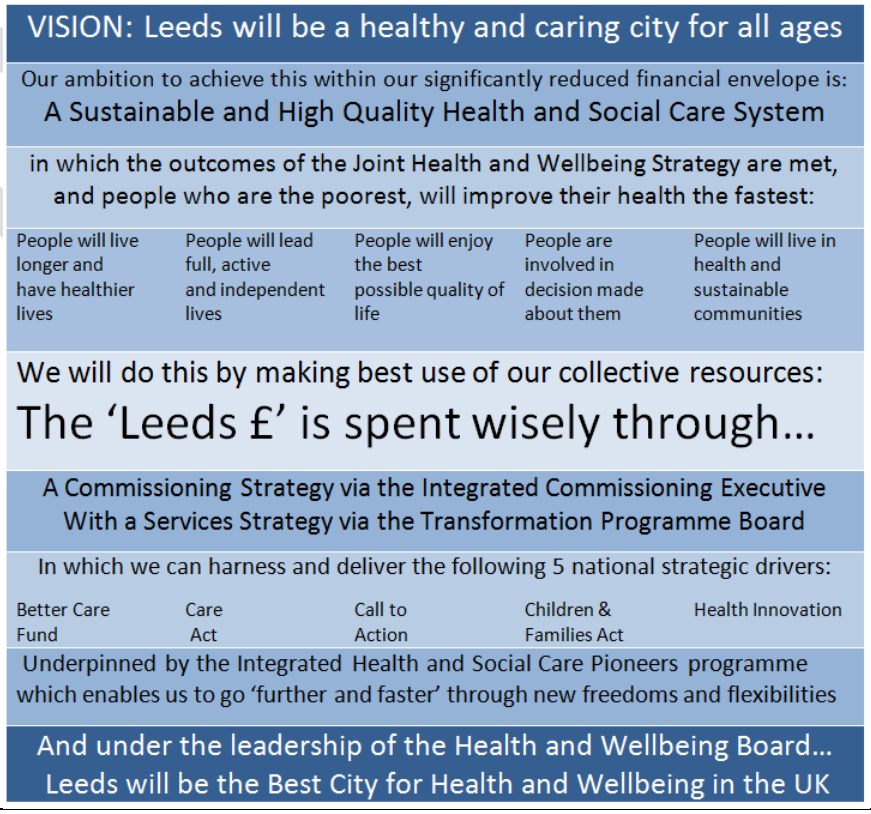
Introduction

Leeds has an excellent record of integrating health and social care, and is one of only 14 Integration Pioneers nationally (see appendix 11 for our Pioneer expression of interest). As such, the city has been in a strong position to develop a joint plan for the BCF locally. A great deal of work has been undertaken by colleagues across the health and social care system in a short space of time to ensure that a quality plan can be developed. Leeds' existing commitment to working together and joining up services around the needs of people, not organisations, has stood the city in good stead.

Leeds has developed the concept of the 'Leeds £' which is a move away from organisations thinking of the most effective way to spend their individual budgets towards thinking of how these budgets are the collective budget of the city and how they can collectively be directed to meet the needs of the people of Leeds.

There is already a strong history of successfully delivering outcomes through pooled budgets within the Leeds health and care system (Learning Disabilities, Joint Mental Health Partnership, Community Equipment Service, Integrated Health and Social Care Teams, Leeds Care Record and other section 75 / 256 agreements).

The following diagram (full version can be found in appendix 1) explains how the Leeds £, vision in Leeds and collective governance work together.



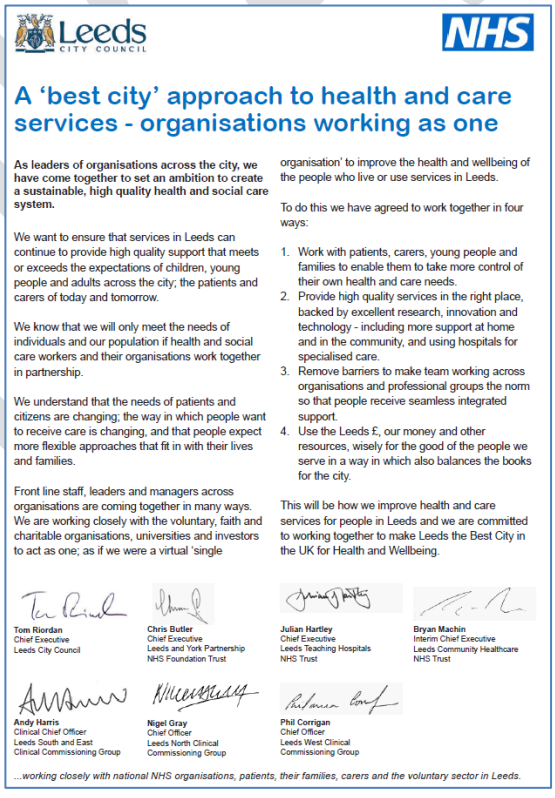
Vision for integrated health and care services

For the past two years, the health and social care community in Leeds has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on our wider vision.

The 5 year strategy sets out a modern model of integrated care, which is detailed below:

- Ensuring we understand individuals and populations:
  - Who are at risk now and in the future and
  - They are known to the health and social care system.
- Developing community based service models that are
  - Clinically integrated across social, primary, community and secondary care and
  - Incorporate the principles of the House of Care model.
- Building trust and understanding between the different cultures within health and care to ensure effective working with clear accountability.
- Aligning incentives across multiple providers by developing common outcomes, indicators and performance measures.

As a Pioneer, Leeds strives to be the Best City for Health and Wellbeing in the UK. Our vision is that Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest. As part of becoming the Best City, commissioners and providers have a shared ambition to create a sustainable, high quality health and social care system as signed up to in the joint statement below (agreement can be found in appendix 2).



Leeds CITY COUNCIL

NHS

A 'best city' approach to health and care services - organisations working as one

As leaders of organisations across the city, we have come together to set an ambition to create a sustainable, high quality health and social care system.

We want to ensure that services in Leeds can continue to provide high quality support that meets or exceeds the expectations of children, young people and adults across the city; the patients and carers of today and tomorrow.

We know that we will only meet the needs of individuals and our population if health and social care workers and their organisations work together in partnership.

We understand that the needs of patients and citizens are changing; the way in which people want to receive care is changing, and that people expect more flexible approaches that fit in with their lives and families.

Front line staff, leaders and managers across organisations are coming together in many ways. We are working closely with the voluntary, faith and charitable organisations, universities and investors to act as one; as if we were a virtual 'single organisation' to improve the health and wellbeing of the people who live or use services in Leeds.

To do this we have agreed to work together in four ways:

1. Work with patients, carers, young people and families to enable them to take more control of their own health and care needs.
2. Provide high quality services in the right place, backed by excellent research, innovation and technology - including more support at home and in the community, and using hospitals for specialised care.
3. Remove barriers to make team working across organisations and professional groups the norm so that people receive seamless integrated support.
4. Use the Leeds £, our money and other resources, wisely for the good of the people we serve in a way in which also balances the books for the city.

This will be how we improve health and care services for people in Leeds and we are committed to working together to make Leeds the Best City in the UK for Health and Wellbeing.

Tom Riordan
Chief Executive
Leeds City Council

Chris Butler
Chief Executive
Leeds and York Partnership NHS Foundation Trust

Julian Hartley
Chief Executive
Leeds Teaching Hospitals NHS Trust

Bryan Machin
Interim Chief Executive
Leeds Community Healthcare NHS Trust

Andy Harris
Clinical Chief Officer
Leeds South and East Clinical Commissioning Group

Nigel Gray
Chief Officer
Leeds North Clinical Commissioning Group

Phil Corrigan
Chief Officer
Leeds West Clinical Commissioning Group

...working closely with national NHS organisations, patients, their families, carers and the voluntary sector in Leeds.

Agreement for a high-quality health and social care system

We recognise that collectively planning improved care and support services requires significant transformation of existing methods of service delivery. Greater emphasis needs to be placed on community-based support and care and significantly less emphasis on the use of acute, urgent and long term care services. Our programme of work acknowledges that people rightly expect the availability of high quality, easily accessible community-based services which they can trust.

A recent example of the approach outlined above is the South Leeds Independence Centre (SLIC), a jointly commissioned and provided intermediate care centre in a community setting. It is designed to provide reablement and rehabilitation to enable people to spend less time in hospital. Our ambition over the next five years, through continuous evaluation and learning from elsewhere, is that the people of Leeds will be able to access further community facilities of this nature.

South Leeds Independence Centre (SLIC)

Another example is the Assistive Living Leeds Hub (ALL) - in the final stages of construction - which is a jointly commissioned purposely refurbished hub for all assistive technological needs and services across the city. Schemes 4 and 16 in our BCF plans contribute to the further development of the ALL service as well as expanding the service to 7 day working.

Artist impression of what the completed ALL will look like

Our approach recognises that whilst services are currently delivered by different organisations, organisational boundaries in the future will continue to be more permeable and flexible, with staff working to support and care for people as part of an interdisciplinary endeavour. Services must be based around the needs of people, not around organisations.

Self-care and self-management (supported by Leeds' ambition to be a digital city for health and social care), and the engagement of community, independent and third sector

organisations are key to achieving improved chronic disease management, social inclusion and community cohesion. The continuing close engagement with all provider organisations will remain at the centre of our transformation programme, driving innovation and efficiency.

We need to accurately identify those individuals who would benefit from earlier intervention, maximizing their independence for longer. This requires two elements:

a. Making best use of risk stratification tools to identify those who could benefit most from more targeted and holistic support and care; and
b. Ensuring that those people experience a coordinated and integrated response to their health and social care needs.

Integrated Health and Social Care Teams, covering the whole city, are a key element to wrapping care around the needs of people, their families and their carers. These teams will continue to be developed and enhanced over the next five years to better deliver care closer to home, and are increasingly improving coordination of activity between all health and social care partners. Scheme 16 in our BCF plans - 'enhancing integrated neighbourhood teams' - will contribute to this happening.

Scheme 16 – enhancing integrated neighbourhood teams, and Scheme 5 - 3rd sector provision will enable best use of community services and support. Working on urgent care, reablement and community beds will mean the right people are seen in hospital and can be supported to move into a community / home setting as soon as it is safe and appropriate. Working to improve our information technology offer (Scheme 18), will smooth out data flows and enable staff to work together more effectively to access service user data.

We also recognise that developing a broader range of community-based services will require the collective pooling of resources to effect the movement of funding from acute and long term care models to those new community based services. All BCF stakeholders will continue to experience considerable financial challenges and therefore our transformation programme is designed to generate significant efficiencies across the piece to ensure that the health and care system for the city remains sustainable – and of high quality – in the long term. City leaders acknowledge that this cannot be achieved overnight and thus this plan reflects an appropriate balance between ambition and realism.

Building on a long history of joint commissioning of services, the BCF provides further opportunity to commission services together. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services - the creation of the Better Care Fund enables us to accelerate progress towards that goal, establishing appropriate governance and ensuring the appropriate sharing of risk and reward.

JSNA

The Leeds Joint Strategic Needs Assessment was published in 2012, and formed the basis on which the city came together to agree its Joint Health and Wellbeing Strategy in 2013. It demonstrates that Leeds has a clear social gradient in its health and life quality, a large difference in life expectancy between the wealthiest and least wealthy communities, and a number of clear reasons behind poor health in the city, including smoking rates, unhealthy eating and alcohol abuse. The findings of the JSNA tell a story

about the conditions and populations most likely to be affected by services delivered by multiple teams and organisations. The core groups identified within this assessment were found to be people with Long Tern Conditions (LTCs), people with complex needs, and people over 75.

The approach of the JSNA is to organise findings into Data Packs (here) which focus on specific conditions such as Cancer, CHD, Diabetes, Hypertension, Dementia and Respiratory diseases, and are used by commissioners as part of the evidence base for the commissioning of services. One pack specifically covers patient feedback from the national GP survey on LTCs, and there are several packs which include data on service utilisation. Some examples of insights relevant to integration in these packs include:

- Dementia and co-morbidity - In line with national trends, dementia prevalence is rising in Leeds, and while 'as a primary diagnosis it features in a relatively low number of acute hospital admissions, it is thought to be a significant factor in admissions for other conditions … It has been estimated that 40% of people aged 65 or over in acute hospitals at any one time (or 25% of all people in hospital) have dementia.' The JSNA notes that 'analysis of adult social care data indicates that people in less deprived areas, who are more likely to be self-funding for social care, are the lowest users of services. Therefore there may be gaps in access to important information, advice and assessment services for older people with age-related dementias'. Accordingly, dementia is a focus within our transformation programme and BCF as described in Schemes 12 and 13. Scheme 12 aims to develop Eldercare Facilitators to focus on patients with dementia and other frail mental health illnesses and link integrated neighbourhood teams, carers and patients and provide support and navigation to local services. Scheme 13 aims to improve medication prompting for people with memory problems to avoid hospital admission caused by adverse reaction and potential multiple conditions treatment/co-morbidities.
- Hospital admissions for hip fracture - Three-year average rates of hospital admission for hip fracture among residents in deprived Leeds are significantly higher than Leeds overall, while rates for females are significantly higher than for males. The JSNA notes that 'fall prevention programmes can be effective in reducing the number of people who fall and the rate of falls. Targeted strategies aimed at behavioural change and risk modification for those living in the community appear to be most promising. Intervention programmes that include risk factor assessment and screening have been shown to be effective. Scheme 14 in our BCF plans contributes to addressing this need. As part of the scheme, the existing falls service will be reviewed, gaps and improvement identified and a model designed fit for the future which can respond to urgently to people who have had a fall who do not necessarily need acute hospital care but who cannot be left alone.

Furthermore, with regard to integration the 2012 JSNA tells us that that:

'We need to move towards the holistic management of people with long term conditions, focusing on the individual and their mental as well as physical needs, rather than on specific disease pathways:

- Co-production and self-care as overall principle running throughout the whole

approach;
- Long term conditions including dementia will become more widespread as the population ages, as will the number of older people caring for a spouse or other family or friend with these needs;
- In the future, outputs from the risk stratification tool used in primary care will give us more data about those living with more than one long term condition.

A new JSNA for Leeds is currently being written, planned to be a rolling programme of live and responsive needs assessment for the city, giving commissioners unrivalled insight into the key areas for the buying and contracting of services to focus on. Future plans for the JSNA relevant to integration efforts include better understanding of comorbidities, the distribution of LTCs, more patient voice, an emphasis on the delivery of services in relation to patient experience of multiple teams/organisations. The JSNA will also foster further understanding of how need matches activity and outcome to help us understand if we are getting value for money.

The Joint Health and Wellbeing Strategy

The Leeds Joint Health and Wellbeing Strategy 2013 has as its second outcome that 'people will live full, active and independent lives', with the key emphasis driving the vision of integration. This filters down into three service priorities around the integration of health and social care:

- To increase the number of people supported to live safely in their own home
- To ensure more people recover from ill health
- To ensure more people cope better with their conditions

These are synonymous with three aims of the BCF. The H&WB Board have laid out their vision for implementing these priorities here.

b) What difference will this make to patient and service user outcomes?

We want to ensure that services in Leeds can continue to provide high quality support that meet or exceed the expectations of the children, young people and adults across the city: the patients and carers of today and tomorrow. We know that we will only meet the needs of individuals and our populations if health and social care workers and their organisations work in partnership and listen to the needs of the population. We know that the needs of patients and citizens are changing; the way in which people want to receive care is changing, and that people expect more flexible approaches that fit in with their lives and families. Front line staff, leaders and managers across organisations are coming together in many ways. We are working closely with not-for-profit organisations, universities and investors to act as one: as if we were a virtual 'single organisation' to improve the health and wellbeing of the people who live or use services in Leeds.

To do this, we have agreed to work together in four ways:

- Work with patients, carers, young people and families to enable them to take more control of their own health and care needs;

- Provide high quality services in the right place, backed by excellent research, innovation and technology- including more support at home and in the community, and using hospitals for specialised care;
- Remove barriers to make team working across organisations and professional groups the norm so that people receive seamless integrated support;
- Use the 'Leeds £', our money and other resources wisely, for the good of the people we serve in a way in which balances the books for the city as described.

With particular regard to Leeds' vision for integrated health and social care and impact on service users, this is based on what local people tell us they want:

> "*Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect"*.

In developing this vision, we identified a common narrative through development of 'I statements' and design principles for integration enables us to identify 'how we will know when we get there'. Using the needs and wants of people accessing services and their carers to form the principles behind our definition of integrated care helps us to ensure that we make changes that can improve outcomes and experiences for people accessing services, through keeping the voice of the citizen at the heart of everything we do. Our outcomes framework (below and full version in appendix 3) gives further detail.

Integrated health and Social Care in Leeds – The Outcomes Framework (developed by The University of Birmingham and Social Care Institute for Excellence)

	Better	Simpler	Better value
Service user and carer	I have choice and control over the services I get. Services see and treat me as an individual. I feel there is time for staff to listen to me.	Teams share information (with my consent), so I don't have to tell my story to too many different people. I know who go to if I need to discuss my support. I am seen in hospital swiftly if that's the best place for me	Formal services help me to make good use of everyday, community services and support. I can get the support I need to manage my own condition.
Staff	Service users receive a more holistic response because we're integrated. Integration enables us to use planning and meeting time more effectively. We are able to take a more preventative approach to support.	I can spend more time with users and carers because we're integrated. I am clear about my role and responsibilities and how they fit with other roles in the whole system.	There is less duplication because we're integrated. Processes (assessment, recording and review) are streamlined and transparent. We have clear ways of sharing learning and best practice between teams.
System	Integrated teams have led to improved health and well-being. Information flow between teams and to and from the wider system (Third sector) is better.	Integrated teams have led to shorter times from referral to response. There is a shared care plan across all relevant partners.	Integrated teams have helped people stay at home (and not go into hospital or care homes). There is flexibility in roles (for simple tasks) within neighbourhood teams and the wider system.

Our outcomes framework

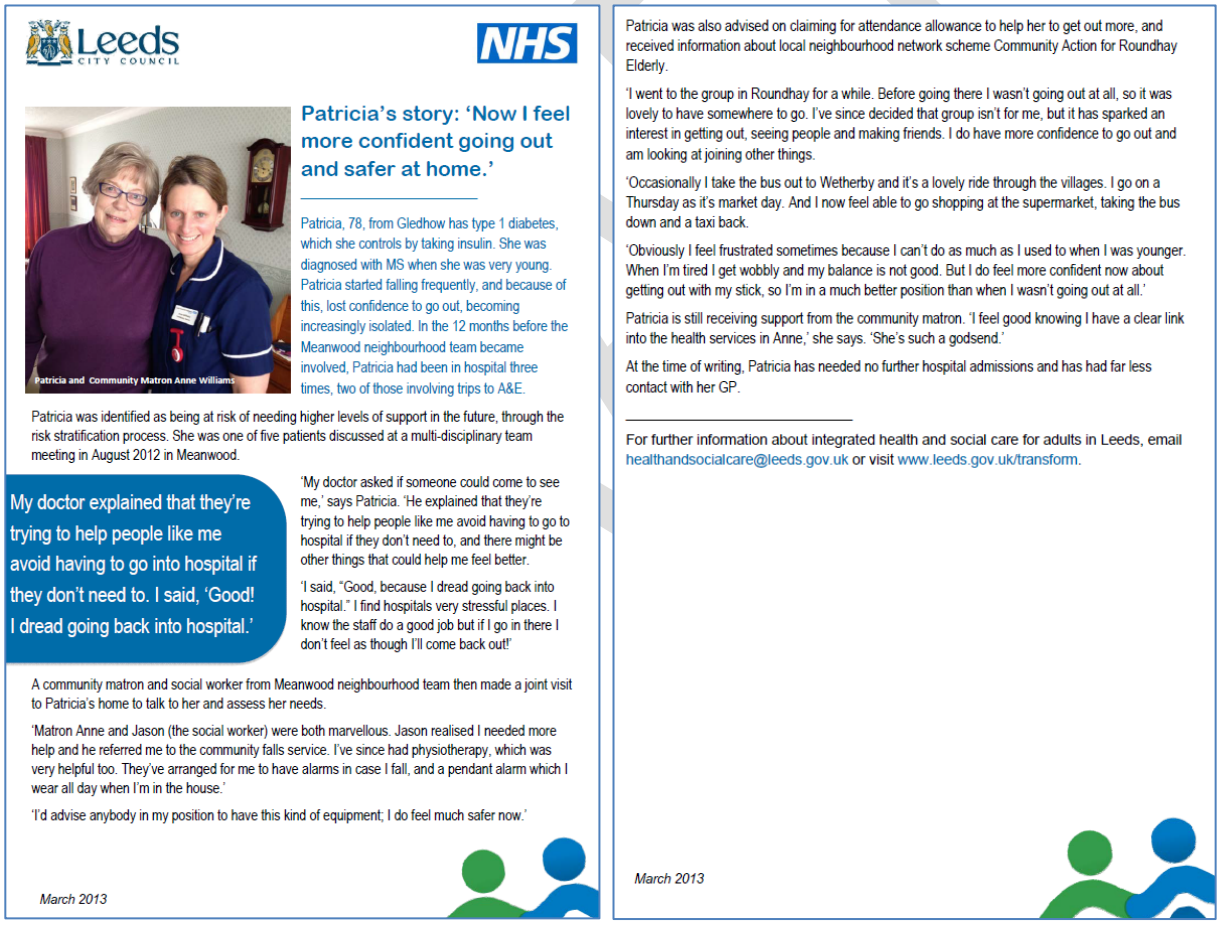
Described in section 8 of this narrative submission is the input and engagement of service users and the public. In line with findings from the HealthWatch consultation we undertook (see appendix 4 for a report on the consultation), it is clear the three objectives of the BCF (Reducing the need for people to go into hospital or residential care; Helping people to leave hospital quickly; Supporting people to stay out of hospital or residential

care) resonate. Service user / patient stories feedback received include:

- *'Given the choice I'd rather get support at home than be in hospital.'* Eileen, 77, Morley

- Jean, 81, from Garforth has type 1 diabetes, and is in remission after being diagnosed with bladder cancer some years ago. When Jean's partner died after a long illness, her community matron put her in touch with Garforth Neighbourhood Elders Team (NET), one of a network of community schemes supporting older people across Leeds. Through the NET, Jean now takes part in a range of different activities throughout the week, and also works there as a volunteer twice a month: *"I want to keep my independence for as long as possible".*

- *'My doctor says they're trying to help people like me avoid having to go into hospital if they don't need to. That's good. I find hospitals very stressful!'* - Patricia, 78, Gledhow (Patricia's full story can be found in appendix 5).



Leeds CITY COUNCIL

NHS

Patricia's story: 'Now I feel more confident going out and safer at home.'

Patricia and Community Matron Anne Williams

Patricia, 78, from Gledhow has type 1 diabetes, which she controls by taking insulin. She was diagnosed with MS when she was very young. Patricia started falling frequently, and because of this, lost confidence to go out, becoming increasingly isolated. In the 12 months before the Meanwood neighbourhood team became involved, Patricia had been in hospital three times, two of those involving trips to A&E.

Patricia was identified as being at risk of needing higher levels of support in the future, through the risk stratification process. She was one of five patients discussed at a multi-disciplinary team meeting in August 2012 in Meanwood.

My doctor explained that they're trying to help people like me avoid having to go into hospital if they don't need to. I said, 'Good! I dread going back into hospital.'

'My doctor asked if someone could come to see me,' says Patricia. 'He explained that they're trying to help people like me avoid having to go to hospital if they don't need to, and there might be other things that could help me feel better.

'I said, "Good, because I dread going back into hospital." I find hospitals very stressful places. I know the staff do a good job but if I go in there I don't feel as though I'll come back out!'

A community matron and social worker from Meanwood neighbourhood team then made a joint visit to Patricia's home to talk to her and assess her needs.

'Matron Anne and Jason (the social worker) were both marvellous. Jason realised I needed more help and he referred me to the community falls service. I've since had physiotherapy, which was very helpful too. They've arranged for me to have alarms in case I fall, and a pendant alarm which I wear all day when I'm in the house.'

'I'd advise anybody in my position to have this kind of equipment; I do feel much safer now.'

March 2013

Patricia was also advised on claiming for attendance allowance to help her to get out more, and received information about local neighbourhood network scheme Community Action for Roundhay Elderly.

'I went to the group in Roundhay for a while. Before going there I wasn't going out at all, so it was lovely to have somewhere to go. I've since decided that group isn't for me, but it has sparked an interest in getting out, seeing people and making friends. I do have more confidence to go out and am looking at joining other things.

'Occasionally I take the bus out to Wetherby and it's a lovely ride through the villages. I go on a Thursday as it's market day. And I now feel able to go shopping at the supermarket, taking the bus down and a taxi back.

'Obviously I feel frustrated sometimes because I can't do as much as I used to when I was younger. When I'm tired I get wobbly and my balance is not good. But I do feel more confident now about getting out with my stick, so I'm in a much better position than when I wasn't going out at all.'

Patricia is still receiving support from the community matron. 'I feel good knowing I have a clear link into the health services in Anne,' she says. 'She's such a godsend.'

At the time of writing, Patricia has needed no further hospital admissions and has had far less contact with her GP.

For further information about integrated health and social care for adults in Leeds, email healthandsocialcare@leeds.gov.uk or visit www.leeds.gov.uk/transform.

March 2013

Patricia's story

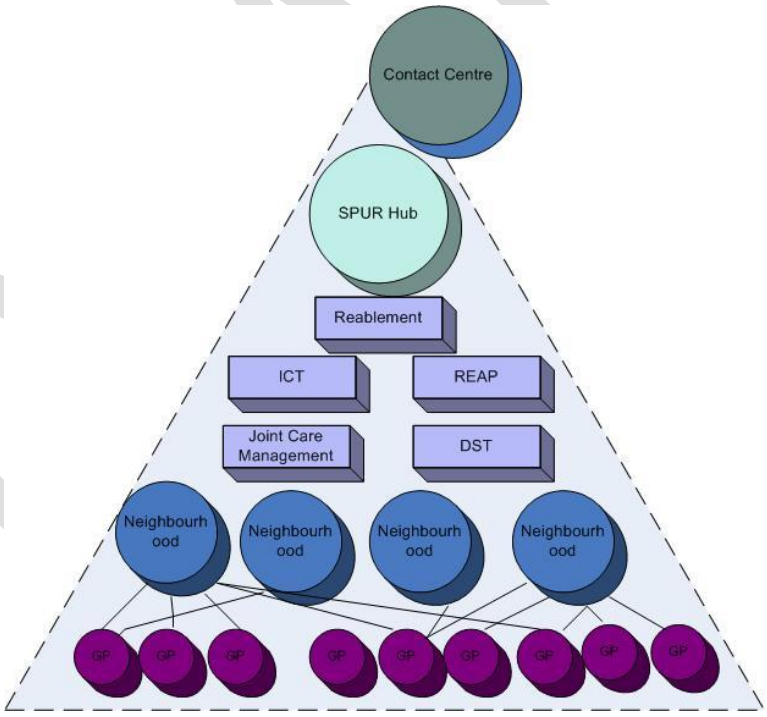
Our BCF is geared towards contributing to a high quality and sustainable health and social care system, through the broader Transformation Programme. In particular, the schemes will support the work programme "Effective admission and discharge" - Integrated management of patients to reduce dependence on secondary care beds. Programme will focus on; preventing admission from A&E, early supported discharge,

appropriate discharge and prevention of re-admissions. BCF Schemes 2, 11, 15, 16 and 17 will also contribute to this. These objectives should result in a better experience for people of Leeds underpinned by the following key principles: the appropriate level of care provided closer to home, a focus on self-management, joined-up care across multiple providers, urgent care should become planned care as far as possible, we must use the latest technology to enable patients to be seen by the right professional at the right time in the right place and involvement of patients and service users is crucial to meeting the challenge.

Care and support

Where we were…

1. We had a broad sign up to an integrated care and support Target Operating Model but no detail of what this would look like in practice.
2. Discovery not design, which meant working practice was not consistent across teams which therefore meant that service user experience could be inconsistent.
3. No phased implementation with a view that change needed to be Citywide quickly, impacting staff and service users at the same time.
4. Last three neighbourhoods to co-locate had been in place for three months.
5. Three Single Point of Urgent Referral (SPUR) hubs and lots of faxes.

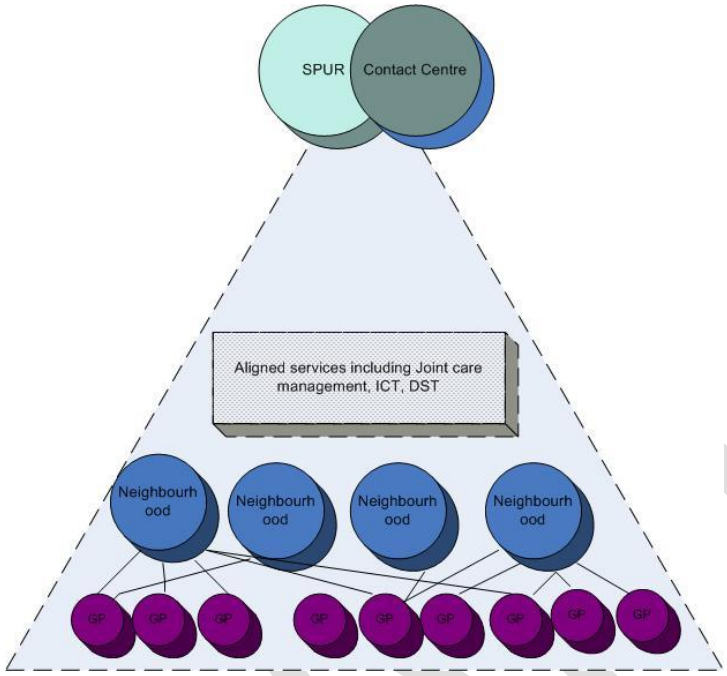


Where we were

Where we are now…

- Detail of model informed by consultation, engagement and testing.
- Single SPUR co-located within Contact Centre.
- Neighbourhoods supported by team co-ordinators and have consistent practices that support integrated working.

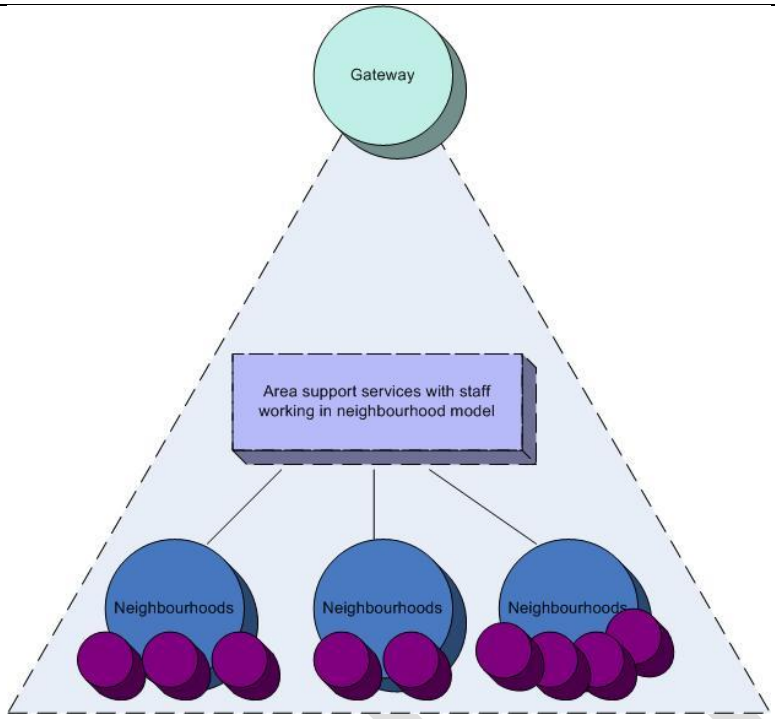
- Much more involvement from 'wraparound' services.
- Projects such as the including South East Initiative have supported the development of a model - avoiding a phased rollout but mitigating risk of a 'big bang'.



Where we are now

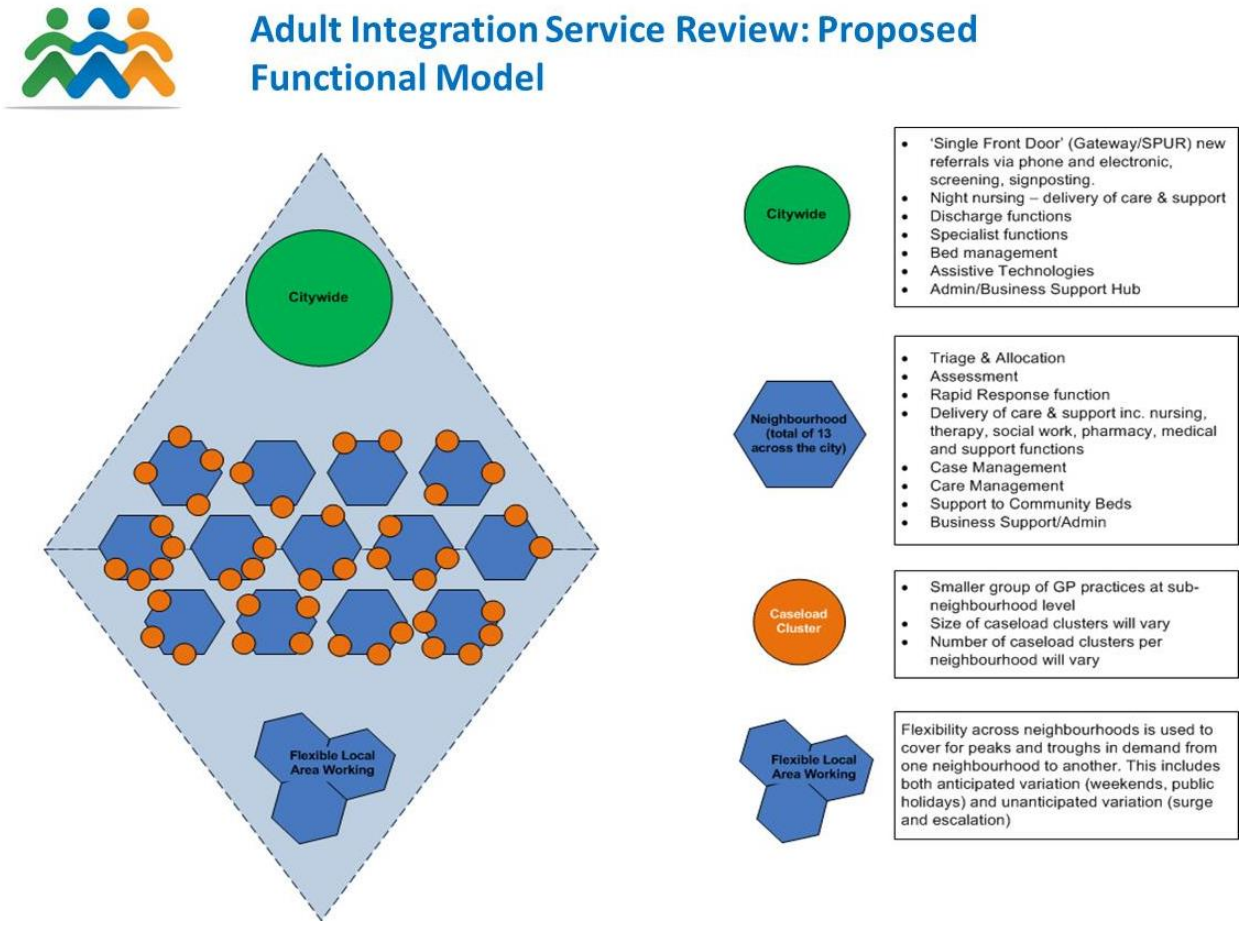
Where we plan to be…

- Community nursing, therapy and social work working much closer together
- Working in local communities in partnership with primary care and other organisations working in that locality
- Single front door to support 'right place first time' approach
- More proactive care
- Joined up 'reactive' care



Where we plan to be

The following diagram describes what the proposed care and support model will look like.

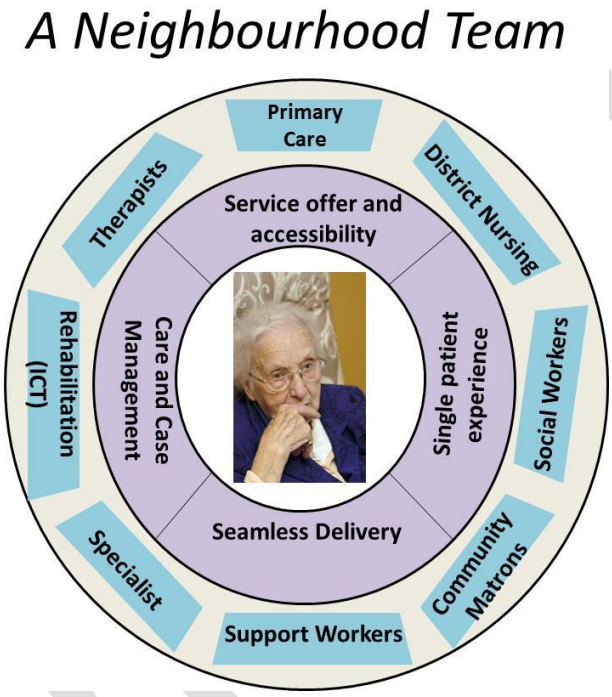


Proposed functional model for care and support

What will this mean for service users…

- More people will have a case manager joining up their health and social care services.
- Proactive support will help people maintain their health and wellbeing for longer and ensure they have the tools to help them manage their condition.
- When people become un-well services will be better organised to help them remain at home. If they do need a period of time in hospital then community and hospital services will work closely together to ensure a safe and timely discharge.

The following diagram describes what the proposed care and support model provided in the Integrated Neighbourhood Team will look like and what this will mean for the service user.



Proposed components of the Neighbourhood Team and the service user experience

A recent evaluation of our integrated care teams tell us we are already making good progress and below are examples of the feedback we have received:

- *"I have choice and control over the services I get"*
- *"Services see and treat me as an individual"*
- *"I feel there is time for staff to listen to me"*
- *"Teams share information (with my consent), so I don't have to tell my story to too many different people"*
- *"I know who to go to if I need to discuss my support"*
- *"I am seen in hospital swiftly if that's the best place for me, and I am supported to get back home again"*
- *"Formal services help me to make good use of everyday, community services and support"*

- *"I can get the support I need to manage my own condition*."

We are already on this journey; as a result of our BCF plan, by April 2016 we will have progressed further. In five years time we anticipate this will be the norm for the people of Leeds.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The Leeds approach to developing our BCF

It is important to be clear – the BCF is not new money. Over recent years, the city has already moved many of its core health and social care services into a jointly commissioned environment. The BCF therefore, offers an opportunity to enhance, refine and bring in new governance arrangements around this existing portfolio of jointly commissioned services and commission more services jointly. The existence of these schemes demonstrate Leeds' track record in integrating health and social care services, and that we are already delivering well against the national outcome indicators.

The model below sets out how the BCF fits into this, alongside other key strategic drivers and making best use of the freedoms and flexibilities of the Pioneer programme**.**

Building on a long history of joint commissioning of services, the BCF provides further opportunity to commission services together. Our ultimate ambition remains the pooling of all current resources committed to the commissioning of health and social care services - the creation of the Better Care Fund enables us to accelerate progress towards that goal, establishing appropriate governance and ensuring the appropriate sharing of risk and reward.

In order to manage the fund we have made the decision to sub-divide the fund into schemes that support these already well-established joint commissioned and/or jointly provided services, and new schemes that provide "invest to save" opportunities.

2014/15 will be used as a shadow year to "pump prime" the Better Care Fund proposals, to help ensure that the city will benefit from and be able to maximise the opportunities from the BCF as soon as possible, in line with both its aspirations and Pioneer status to go further, faster. As the BCF does not come into being until 2015/16, during 2014/15 the

funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year. The figures set out in our template represent CCG and local authority allocations for this work next year to work up and test out the "invest to save" opportunities, and the likely minimum values that will be allocated to these same schemes in 2015/16 that will go into the live BCF.

Many of the "pump-priming" schemes have been allocated funding in 2014/15 to scope and develop robust business cases that will evidence, as far as possible, return on investment, anticipated shift in activity and impact on the acute sector. This is so we can accurately model and monitor once the BCF goes live in 2015/16 and ensure we are investing the full fund into the right schemes that will meet our objectives set out below. If schemes cannot demonstrate a Return on Investment through the business case development phase, they will be withdrawn from the BCF.

Leeds has chosen to take this approach to make sure it is in the strongest position possible to benefit from the BCF in 2015/16. 2014/15 is effectively a year-long planning exercise, allowing us to test out assumptions, develop robust and accurate evidence of benefits and provide an agile and flexible response to the key question of "is this scheme working for Leeds"? This will help to mitigate the risks set out in section 5a.

Aims

As an Integration Pioneer, we will be aiming:

- To be recognised as a national and international centre of health and social care excellence
- To be recognised as city which is leading the way on health and care innovation
- To have the ability to make commissioning and de-commissioning decisions on the basis of shared empirical, financial and outcome intelligence

In developing the BCF, partners have recognised the importance not only of integrated provider services, but also the need to increasingly jointly commission these services. As such, the Transformation Board programme aims to achieve:

- Better outcomes for the people of Leeds
- Timely access to personalised services
- More effective use of resources
- Better collaborative use of the Leeds £
- Better lives for people in Leeds through integrated services

Objectives

The specific schemes within the Better Care Fund are framed by three key objectives to achieve the aim of a high quality and sustainable system. These themes also articulate delivery of a number of the outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the commitment to "increase the number of people supported to live safely in their own homes", will support delivery of the broad Transformation Programme and specifically align to the Effective admission and discharge work programme.

Our BCF objectives are:

- Reducing the need for people to go into hospital or residential care
- Helping people to leave hospital quickly

- Supporting people to stay out of hospital or residential care.

Table showing which of the schemes best contribute to the Leeds BCF objectives. See annex 1 for detailed descriptions of each scheme and what changes they intend to deliver.

Scheme Number	Name of scheme	Leeds BCF objectives		
		Reducing the need for people to go into hospital or residential care	Helping people to leave hospital quickly	Supporting people to stay out of hospital or residential care
1	Reablement services	X		X
2	Community beds		X	
3	Supporting Carers	X		X
4	Leeds Equipment Service	X		X
5	3rd sector prevention	X	X	X
6	Admission avoidance			X
7	Community matrons	X	X	X
8	Social care to benefit health	X	X	X
9	Disabilities facilities grants	X	X	
10	Social care capital grant - Care Act	Enabling		
11	Enhancing primary care	X		
12	Eldercare Facilitator	X		X
13	Medication prompting - Dementia	X		
14	Falls	X		
15	Expand community Intermediate Care beds		X	
16	Enhancing Integrated Neighbourhood Teams	X	X	X
17	Urgent Care Services	X		
18	IM&T	Enabling		
19	Care Act	X	X	X
20	Improved system intelligence	Enabling		
21	Workforce planning & development	Enabling		
22	Contingency Fund	-		

What we will measure

These objectives will be measured by the nationally required metrics of the BCF. We have chosen to use the dementia diagnosis rate as our "local" measure, given the focus on supporting people with dementia in our schemes and the role this can play in achieving better outcomes across our three themes.

However, there exist some local concerns about the nationally required metrics for measuring effectiveness. In Leeds, we have taken the decision to develop two additional local metrics:

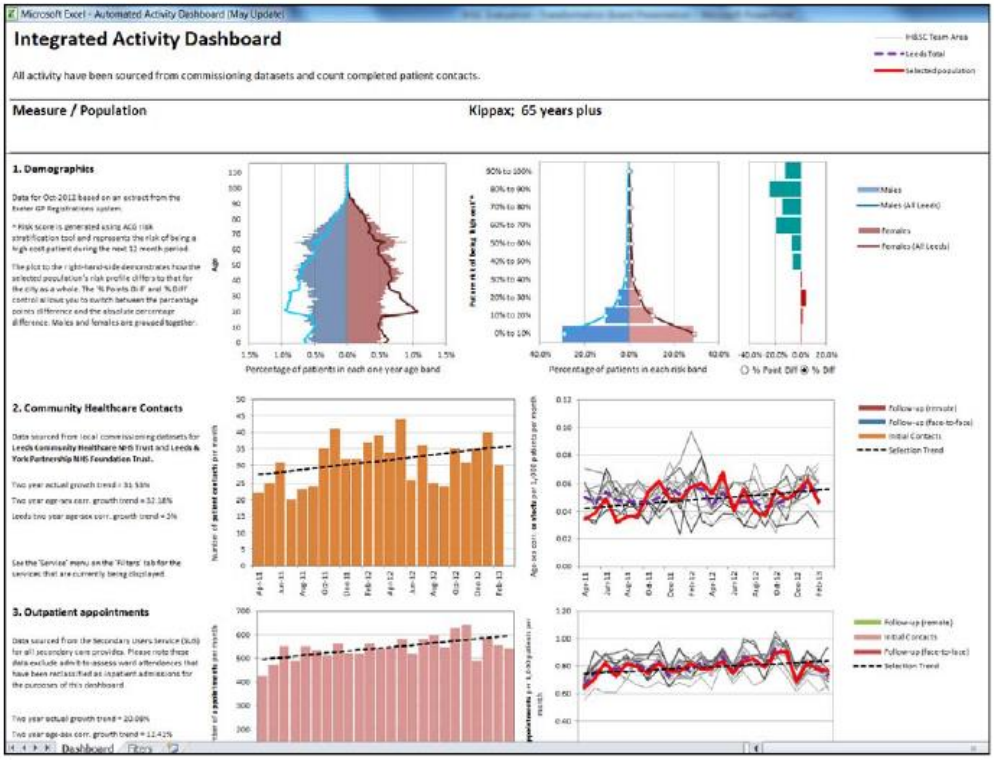
- Our indicator will focus on the total number of bed days spent in care/residential home facilities. In Leeds, we believe that our success in supporting more people to live longer in their own homes is evidenced not by the rate of admissions to residential care, but by the combination of those admitted and their lengths of stay. This number has steadily reduced over the last 10 years.
- We are also looking at developing a measure relating to bed day utilisation across

the whole health and social care system.

In terms of overall health gain, the overarching population level indicator of our Joint Health and Wellbeing Strategy is the reduction of differences in life expectancy between communities. Further detail and rationale on the metrics we will use as a city is available in the spreadsheet and our approach to this has been detailed in our covering note.

How we will measure

There are positive signs from the Leeds Integrated Health & Social Care Outcome Framework (appendix 3) that suggest progress can be measured, and we continue to evaluate progress using this tool within Leeds. Additionally, effectiveness of integration has been embedded into city wide analysis through the use of a dashboard approach (below and further detail in appendix 6).



We will continue to use this as part of the BCF monitoring system. In addition to this, we will monitor:

- Progress towards individual organisations and the health economy of Leeds achieving financial balance
- Using 'Caretrak' (our innovative product which tracks patient populations across the health and social care system based on use of the NHS Number) to ascribe both clinical and financial value to intervention
- Progress on the Joint Health and Wellbeing Strategy indicators especially those related to hospital admission, discharge rate and readmission as per the three objectives of our BCF.

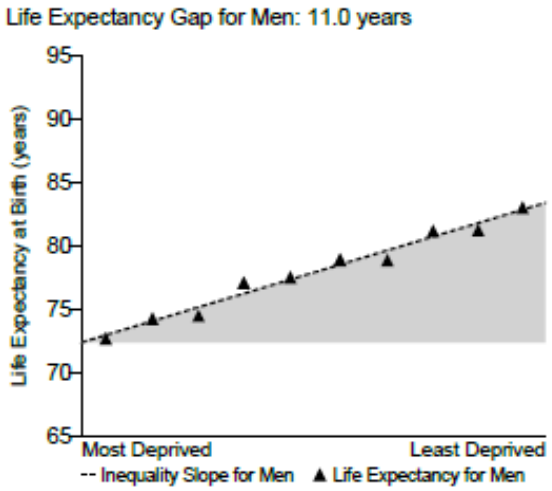
Achieving the objectives set out above will enable us to fully realise the potential from our Pioneer status, both in terms of transforming services for better outcomes for the people of Leeds and sharing our learning across the country.

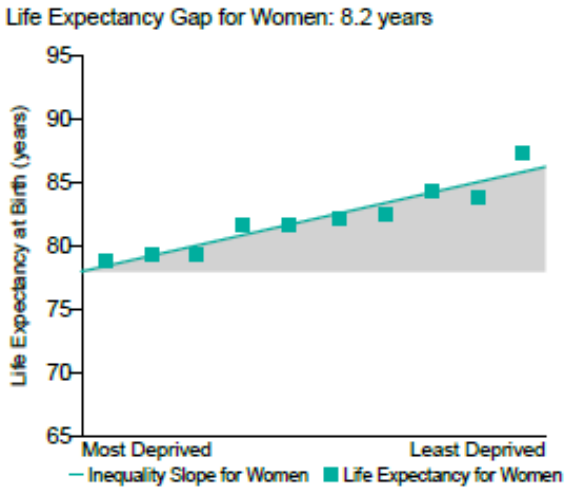
3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

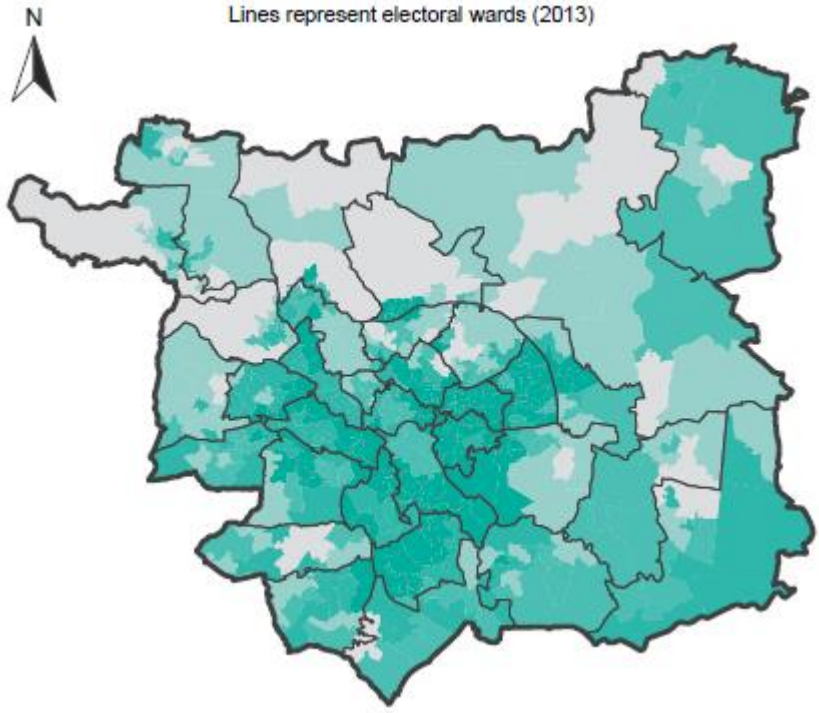
As described in our JSNA, Leeds is a diversity city comprising of multiple communities each with their own specific health and social care needs. We know significant health inequalities persist in Leeds between the most affluent communities that are typically on the outer fringes of the city, and the most economically-challenged communities that cluster around the inner city. Recent work by public health England shows Life expectancy is 11.0 years lower for men and 8.2 years lower for women in the most deprived areas of Leeds than in the least deprived areas.

The charts below show life expectancy for men and women in Leeds for 2010/12. Each chart is divided into tenths by deprivation, from the most deprived on the left of the chart to the least on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation – if there were no inequality the line would be completely horizontal.





In terms of geography, this deprivation is clustered in the centre and to the south of the city, but there are pockets of deprivation across the city. This is demonstrated on the map below, with darker colours indicating higher deprivation:



This wide spread of deprivation means we need to focus on organising and empowering our already established and recognised neighbourhood teams. In particular, using tools such as risk stratification, we will resource and empower teams according to the need of the area. Schemes in the Leeds BCF will support this to happen.

In addition to this life expectancy gap, obesity and smoking related deaths in the city are also worse than the national average. This means that if we are to achieve our aims of reducing hospital admissions and reduce dependency on other NHS and Adult Social Care services we need to focus not just on services that reduce length of stay or prevent admissions when issues arise, but we need to address some of the longer term, public health issues that blight the city. Leeds has a range of schemes in place to achieve this, around working with the 3rd sector, supporting improved identification of diseases (e.g. dementia) and extra support in primary care to allow GPs to practice more preventative medicine.

We also recognise that our most economically-challenged communities are more likely to access emergency healthcare, and typically seek medical help at a later stage which adversely influences their health outcomes (e.g. late presentations for suspected cancer within our most deprived communities is known to translate into poorer cancer survival rates). The integration of health and social care services that proactively engage and better meet the holistic needs of these communities is central to Leeds's strategy for address health inequalities and rebalancing the provision of services always from reactive unplanned interventions toward more sustainable planned services.

As key enabler to integration, all GP practices in Leeds have access to the Leeds Risk Stratification system that incorporates the ACG™ risk algorithm. This provides clinicians with whole-population risk intelligence to help manage individuals that are predicted to be high users of healthcare in the next 12 month period. This system is supporting practices to deliver the 'Proactive case finding and care review for vulnerable people Enhance Service' and is being used to identify patients that would benefit for community interventions such as the Proactive Case Management service.

Figure 1. Risk profile for all patients registered with GP practices in Leeds generated using the ACG™system.

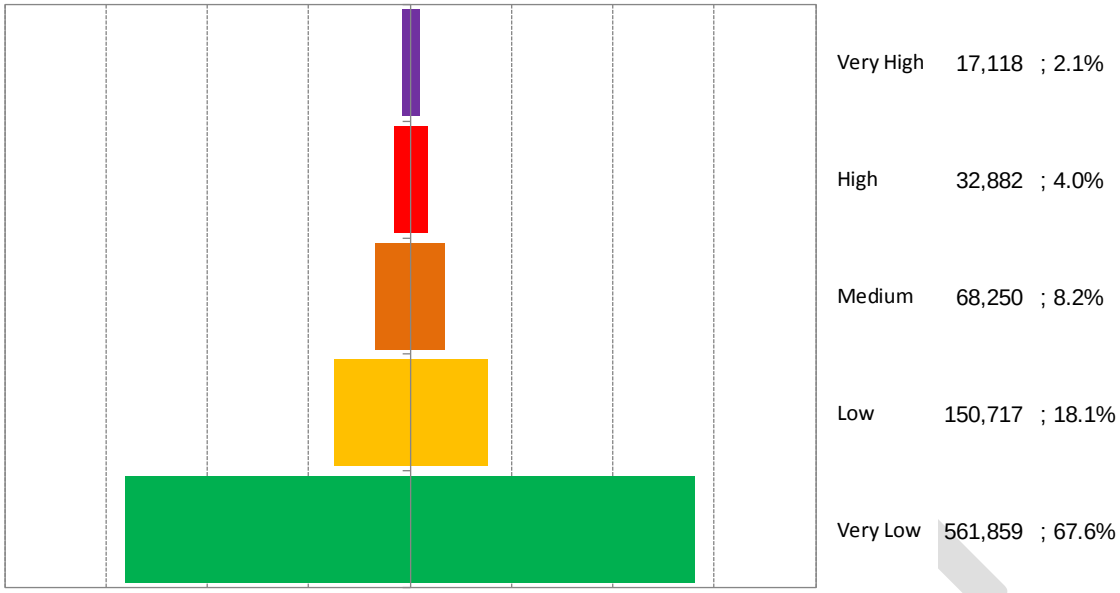
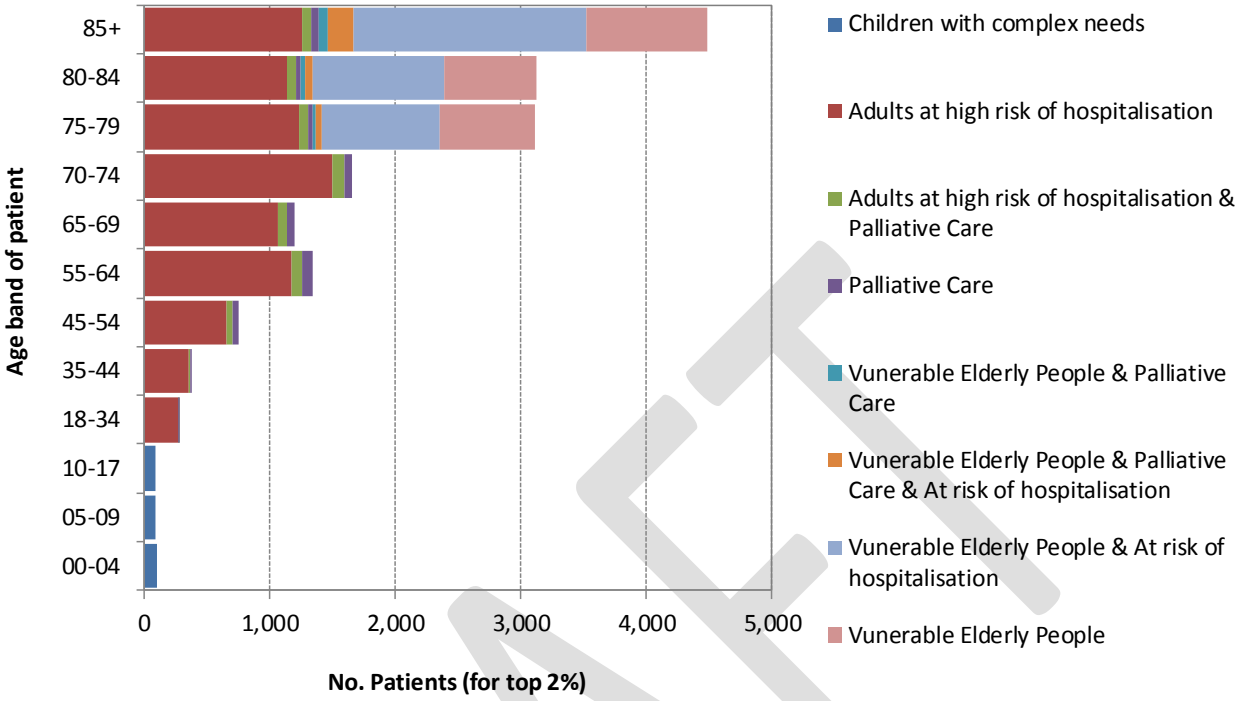


Figure 1 above illustrates the risk profile for Leeds split by risk bands. Just over 2% of the city's population is flagged as of being 'very high' risk, as defined as individuals who are predicted to use 6.8 times or more healthcare resource in the next 12 months compared to the average person. We know this cohort is skewed towards more elderly patients and includes those at risk of hospitalisation, vulnerable 'frail' patients and those identified as requiring palliative care (see Figure 2). We also know that proportionately more very high risk patients live in the south and east of the city, which is consistent with the link between deprivation and health outcomes, and that the vast majority of this population have multiple-long term conditions – typically four or more.

Figure 2. Breakdown of the top 2% by risk of the Leeds population by age and type of need. Please note cohorts can overlap (e.g. vulnerable elderly patients as defined using a frailty index can also be at high risk of hospitalisation – see pale blue category).

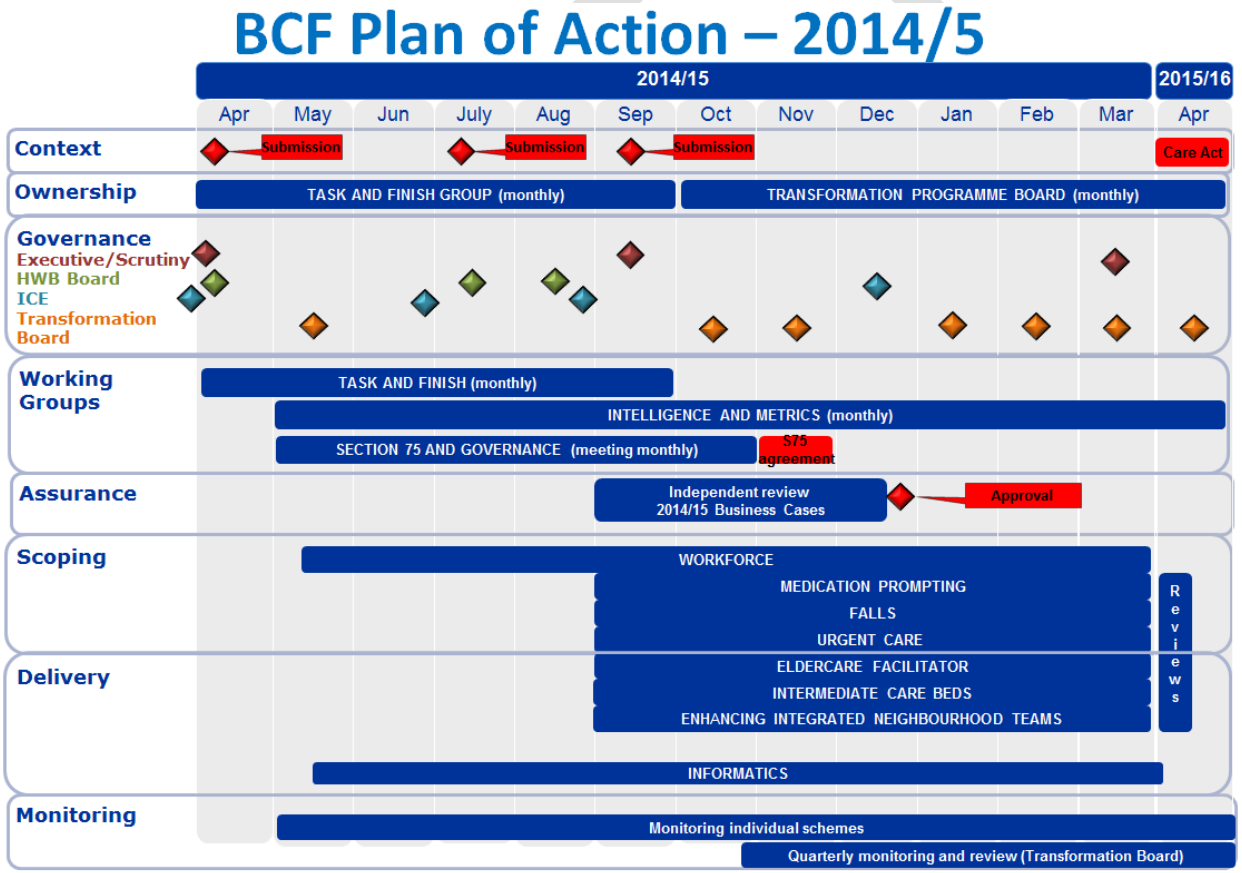


From the intelligence the city has collated we recognise that not all 'at risk' patients are actively being managed and we also know that for certain services that case manage complex patients, not all patients on the service's caseload are flagged as being high risk patients. This suggests that opportunities exist to re-prioritise caseloads to target care at those most in need. Work is continuing to integrate intelligence from health and social care to build a more comprehensive picture of how risk is distributed across our population and what opportunities there may be for focusing services towards areas of unmet need. This work is being co-ordinated by the Leeds Intelligence Hub, which is a joint health and social care analytical service set-up to support the development of the city's BCF and wider transformation plans.

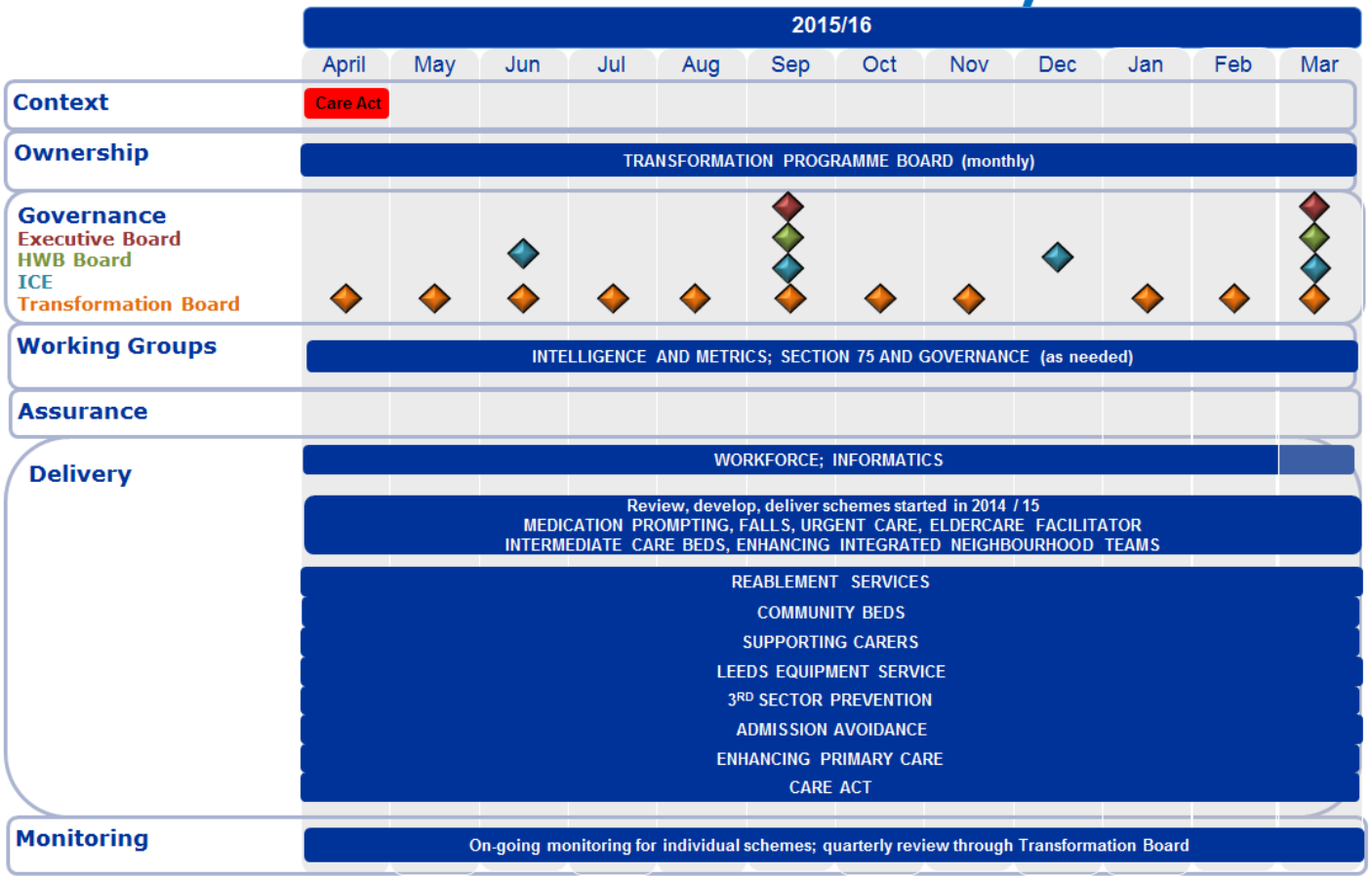
4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The following two diagrams represent the high-level programme 'plans on a page' for the shadow year 14/15 and the BCF year 15/16. We are currently finalising each of the business cases for each of the schemes from which we will be developing a detailed programme plan and corresponding project plan per scheme. These will clearly highlight any dependencies and interdependencies.



BCF Plan of Action – 2015/6



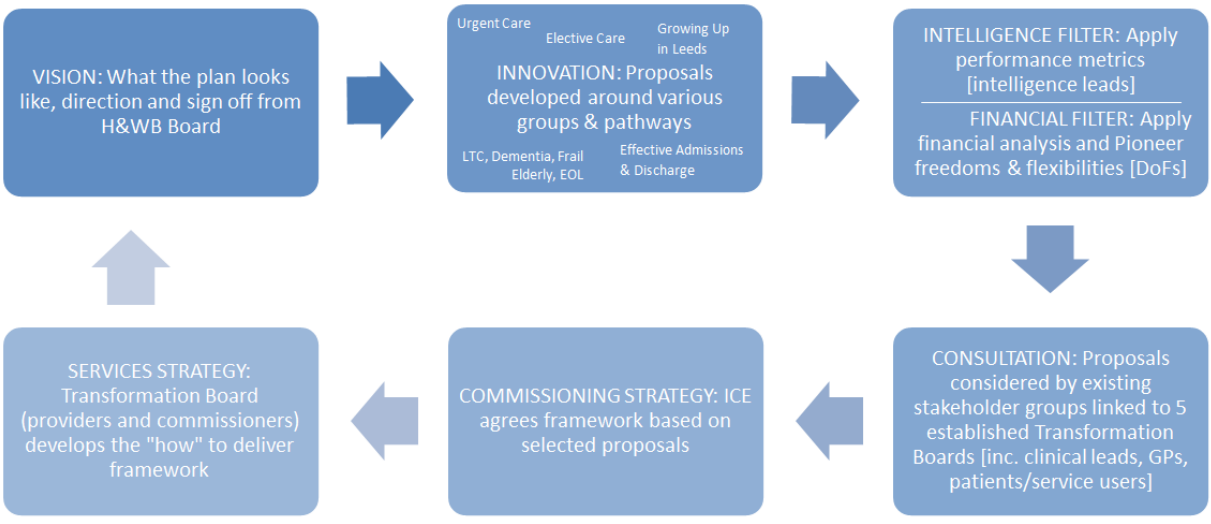
b) Please articulate the overarching governance arrangements for integrated care locally

Leeds has established robust partnership structures and excellent relationships between senior leadership teams from health and social care organisations across the city. There is a real commitment to working together to make the best use of our collective resources to get the best outcomes for Leeds.

Governance for the BCF and associated transformation plans is established; in preparation for the BCF, the Terms of Reference for the Health and Wellbeing Board have been reviewed by Leeds City Council's legal services department. The Health and Wellbeing Board has been closely involved in the BCF process and will retain overall accountability following sign off of the plan. The day-to-day executive leadership and steer for the BCF will be through the Integrated Commissioning Executive (ICE), which is the executive arm of the Health and Wellbeing Board. The Transformation Board provides a forum for all commissioning and provider organisations to actively agree and oversee the delivery of the schemes within the BCF.

With regard to integration of funding between the NHS and Social Care, it is proposed that a Section 75 is put in place for 2015/16, with the local authority acting as the pooled budget holder. For 2014/15, we will be testing out our plans through a Section 256 and potentially a S76, as per recent NHS England guidance.

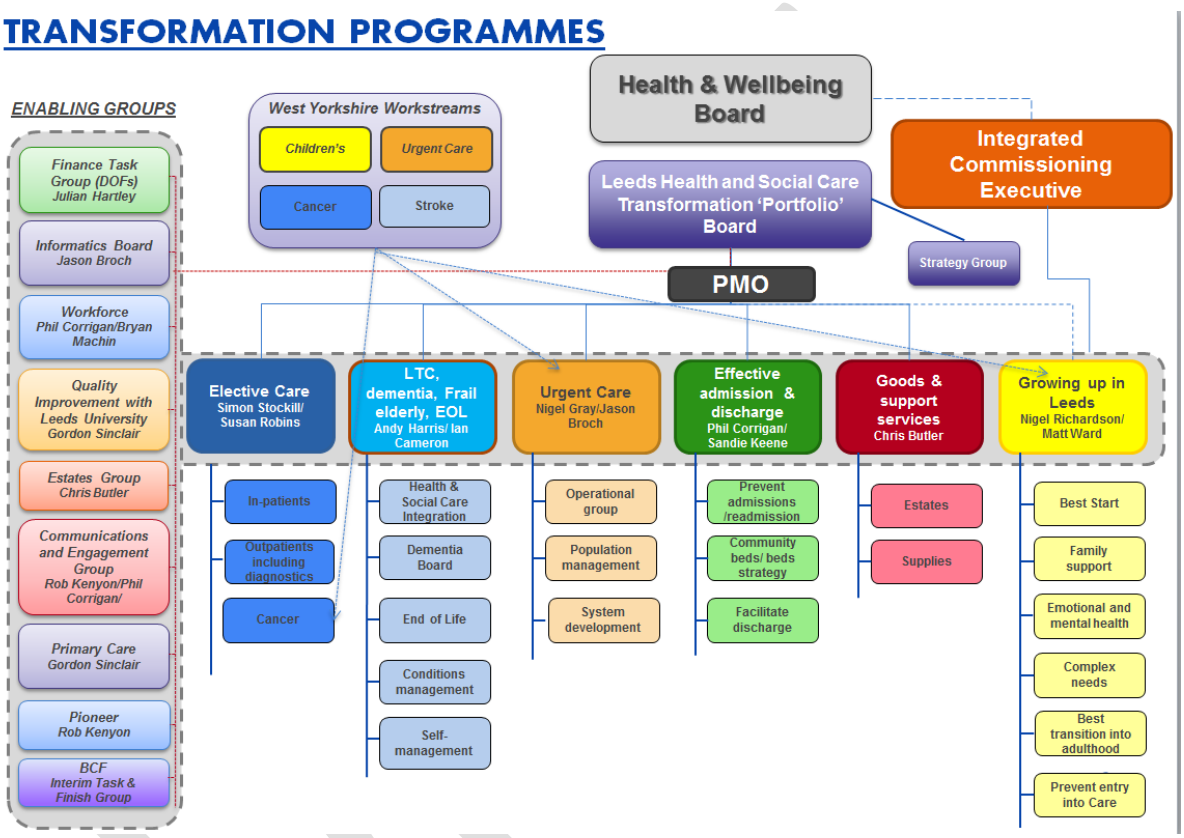
The following is the agreed process for developing all Transformational Changes in the city.



The development of proposals to transform health and social care services will not stop once the BCF has been submitted. The process above will allow the system to make on-going, evidence-based decisions for the best use of pooled budgets for integrated care going forwards. Together with on-going monitoring arrangements, we believe this will ensure that the necessary clinical and financial benefits are realised.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Leeds has established the following Transformation structure which has representation from all key health and social care as well as the 3rd sector (diagram below and full version in appendix 7). Leeds has also recently appointed a Transformation Director to coordinate the transformation structure and approach across the city. Each group/board has its own Terms of Reference and formalised structure and most meet on a monthly basis.



The approach taken in Leeds to manage the development of the BCF was to establish a BCF Task & Finish Group which had senior representation from ASC and one of the three CCGs acting on behalf of the others. This BCF Task & Finish Group has since expanded to include representation from LTHT and LCH as well as the other CCGs and the Transformation Director. This group has been tasked with the programme management role for the BCF to ensure that the necessary activities are undertaken to firmly establish and embed the BCF so that it can then be managed as part of the Transformation structure as business as usual. The Task & Finish Group has reported and escalated any issues to the Transformation Board and ICE in the first instance but has also reported to the Health and Wellbeing Board and Scrutiny.

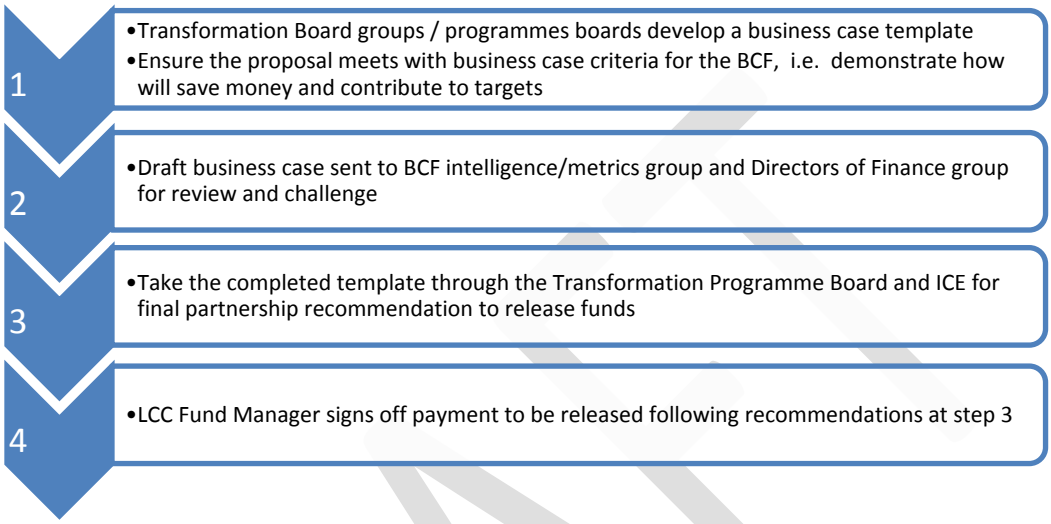
Two additional groups specifically to manage the BCF have also been established.

Firstly, a cross organisation BCF Metrics/Intelligence Group consisting of performance, finance and strategic leads, whose remit it has been to act as the challenger of the business cases to ensure that they are robust with no obvious adverse impacts. The

second group is the BCF Governance Group, whose focus it is to ensure that there are the correct contractual agreements and financial processes in place for each of the schemes and the BCF as a whole.

It is envisaged that once the BCF enters into 2015/16, the BCF Task & Finish Group and the BCF Governance Group can be disbanded and that the BCF Metrics/Intelligence Group will broaden to be the Transformation Intelligence group.

The following describes the business case approval process.



In terms of the project management of each of the schemes on a day-to-day basis, each scheme has been allocated under one of the Transformation groups/boards. From here, any issues will be escalated to the Transformation Board, then to ICE and finally to the Health and Wellbeing Board.

A dashboard is currently being developed as part of the Transformation programme and it is planned to incorporate indicators which will allow monitoring of the BCF schemes. This dashboard will be accessible at all levels of the governance structure and will be regularly monitored so that any appropriate action can be taken if necessary.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
01	Reablement
02	Community beds
03	Supporting carers
04	Leeds equipment service
05	3rd sector prevention
06	Admission avoidance
07	Community matrons
08	Social care to benefit health
09	Disabilities facilities grants
10	Social care capital grant - Care bill
11	Enhancing primary care
12	Eldercare facilitator
13	Medication prompting (dementia)
14	Falls
15	Expand community / intermediate beds
16	Enhancing integrated neighbourhood teams
17	Urgent care
18	Information technology (inc. social care capital grant)
19	Care Bill
20	Improved system intelligence
21	Workforce
22	Contingency

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
The savings released from the schemes are less than the value of the BCF so it is not possible to fund the schemes in subsequent years through the BCF.	2	4	8	• Robust business cases for each scheme. • Business cases undergo rigorous review and challenge. • Schemes monitored through into the city-wide Transformation governance arrangements. • Appropriate action will be taken to address any schemes not meeting targets. Owner: Accountable officers and Transformation sub-group per scheme.
Hospital beds are not closed as activity drops, meaning that any savings are not released.	2	4	8	• Leeds Teaching Hospitals Trust plans outline how beds within the acute sector can be closed without destabilising the sector. • In addition to BCF schemes, LTHT are making a number of changes wider than the BCF to reduce length of stay and close beds. Owner: LTHT executive board
Unable to recruit the necessary workforce to undertake the schemes.	1	4	4	• Each scheme to be costed in terms of resources required for implementation Owner – Scheme Accountable officer. • As part of the Transformation Board there is a specific Workforce strategy group who are looking at how resources can be moved around the system without destabilising another part. Owner: Workforce group.
Work outlined may not adequately ensure the Protection of Adult	2	5	10	• In addition to the BCF there are other schemes being undertaken with ASC as part of the overall Transformation

Social Care services.				Programme, including a £25m Capital programme provided by the Council to improve efficiency, effectiveness and protect adult social care services. Owner: Transformation Board/DoF forum
Operational pressures and the current high volume of business change will restrict the ability of our workforce to deliver the projects needed to make the vision of care outlined a reality.	1	3	3	• Proposals include investment in infrastructure and development to support overall organisational development. Owner: Transformation Board and appropriate sub groups
Improvements in the quality of care and in preventative services will fail to translate into required impact on the national and local metrics.	1	3	3	• Robust business cases for each scheme. • Business cases undergo rigorous review and challenge. • Schemes monitored through into the city-wide Transformation governance arrangements. • Appropriate action will be taken to address any schemes not meeting targets. Owner: Accountable officers and Transformation sub-group per scheme.
The introduction of the Care Act may result in a significant increase in the cost of care provision from April 2016 that is not currently fully quantifiable.	3	4	6	• A Chief Officer with specific responsibility for Social Care Reforms and the Care Act has been appointed. • A Programme specific to plan, manage and monitor the introduction of the Care Act has been established. Owner: Care Act Programme Board / Transformation Board
Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	2	4	8	• Savings generated through work under the Better Care Fund will be used to increase capacity in community and social settings. • There are other schemes outside of the BCF which are also looking at developing the community capacity Owner: Transformation Board

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Contingency
The Leeds Better Care Fund P4P element equates to a 3.5% reduction in emergency admissions. Having adjusted for the impact of the non-elective threshold, calculated using the current 2008/09 agreed baseline, the value of this activity reduction is approximately £2m. On this basis a contingency of that value has therefore been established.

If the assumed reduction in cost of non-elective admissions does not materialise the contingency will be used to pay the acute providers for any over performance on non-elective emergency admissions. If as part of the wider health economy QIPP plans the savings detailed are realised the contingency will be available to the BCF for new investments or to mitigate slippage against the planned metrics in other schemes included in the BCF.

Risk / Financial Management
The delivery of each scheme within the BCF, alongside other city wide transformation schemes, will be managed through the Leeds Transformation Board in conjunction with the Leeds Health and Well Being Board.

The following general principles will apply:

- Schemes are expected to operate within the financial resources that have been allocated to them and to deliver and realise the planned benefits
- Programme Directors will be accountable and held responsible for ensuring that expenditure remains within the budget provision
- Program leads will be responsible for ensuring that all of the commitments are supported by formalised contractual arrangements. These arrangements will include clear service specifications, financial commitments, contractual activity and key performance indicators (KPIs).
- All future commitments will need to be supported by a service specification and a contract with clear financial values, activity targets and KPIs where appropriate.
- In line with the scheme of delegation the Integrated Commissioning Executive and Leeds Health and Wellbeing Board will be responsible for reviewing and approving virements between scheme budgets, along with any re-investment of slippage on the Better Care Fund resources.

There are a number of providers and commissioners within the Leeds Better Care Fund and therefore there are multiple contracts. Schedule 3 of the Section 75 agreement which details the risk sharing arrangements is in development, with a view to including this within all other contracts as part of the BCF.

6) ALIGNMENT

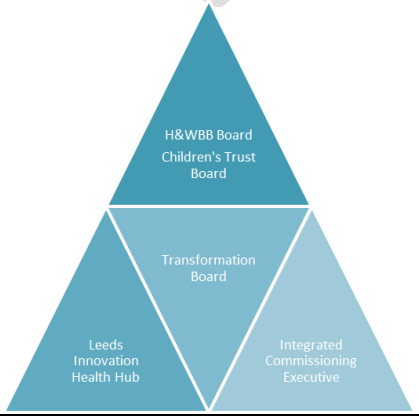
a) Please describe how these plans align with other initiatives related to care and support underway in your area

Leeds has an ambition to be the Best city in the UK (Vision for Leeds) including the best city for health and wellbeing (Joint Health & Wellbeing strategy). We will create a high quality and sustainable H&SC system. The Chief Executives across NHS and local Authority providers and commissioners have come together and signed an agreement to work as if they were a Single Organisation for Leeds (Chief Executive letter referred to in section 2a).

We have established our overall strategic direction through our Health and Wellbeing Board, and this is delivered through the plans within our Transformation Programme and commissioned jointly through our Integrated Commissioning Executive. The service changes described within our BCF will be delivered through the work programme of the Transformation Board (covering areas such as: Elective Care, LTC, Urgent Care, Effective Admission & Discharge and Growing up in Leeds), and the BCF will be commissioned and managed through the Integrated Commissioning Executive as part of our work to make the best use of our collective resources – the Leeds £.

This will sit alongside other current and planned programmes of work and initiatives including but not limited to:

- Pioneer Programme
- Financial modelling
- Payment mechanisms
- Personalisation [including Year of Care and Personalised budgets]
- Leeds Institute for Quality Improvement
- Leeds Innovation Health Hub
- West Yorkshire workstreams
- Informatics Strategy [both local and the national work run from Leeds as part of the Pioneer programme]
- Estates Group
- Workforce Group
- Primary Care co-commissioning
- Capital Investment Fund
- Leeds Intelligence Hub



Like all initiatives, the BCF has been considered and incorporated into the city's ambitions and work within the context of creating a high quality and sustainable H&SC system. Where the BCF enables the city to achieve this ambition it will be embedded into our work to increase alignment and efficiencies. We will use the flexibilities afforded to us as Pioneers to ensure that there are no negative unintended consequences.

There is a single point of arbitration for the city to manage any issues that arise from working as if we were a single organisation, and ultimate approval and sign off rest with our H&WB board.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Leeds' Transformation Programme and 5 Year Strategy

The Leeds Transformation Board has undertaken a development programme to build a shared vision for the city and identify the key areas of focus for transformation activity. This has resulted in the agreement to develop a shared city-wide, health, social care and public health, commissioner and provider strategy for the city. It has identified two key challenges to address sustainability in the system:

- Bring the overall cost of health and social care in Leeds within affordability limits - transformation is required to reduce current costs.
- Change the shape of health provision so that care is provided in the most appropriate setting.

The BCF is a component part of this programme, and we recognise the BCF alone will not have the scale of impact required. As a first step, the Transformation Board has overseen the development of the 5 Year Health Commissioning Strategy (Plan on a Page is set out at appendix 10), agreed by the Leeds Health & Wellbeing Board at its meeting of 18th June 2014. Work on the city-wide strategy will now continue to incorporate the social care, public health, workforce, estates, informatics, infrastructure and provider perspectives in more detail and further refine the economic modelling and measurement processes.

Leeds' recently refreshed Transformation Programme (appendix 7) will ensure delivery against these strategic aims. This has been grounded in an evidence base drawn from the Joint Strategic Needs Assessment, the opportunities identified in the national Commissioning for Value work, commitments within the Better Care Fund and local improvement work. There is an alignment of measurements with the Leeds Joint Health & Wellbeing Strategy.

Leeds CCGs 2 Year Operating Plans for 2014/15 – 2015/16

The three Leeds CCGs developed their 2 Year Operating Plans for 2014/15-2015/16 in response to the NHS England planning guidance *Everyone Counts: Planning for Patients 2014/15 to 2018/19,* and the needs of their local populations. Levels of ambition on a number of nationally identified outcome measures were agreed by the CCGs and the Leeds Health and Wellbeing Board as part of this process, and submitted to NHS England in April 2014. The CCGs' 2 Year Operating Plans are consistent with the BCF

three key objectives i.e.:

- Reducing the need for people to go into hospital or residential care
- Helping people to leave hospital quickly
- Supporting people to stay out of hospital or residential care

There is alignment between the metrics within the 2 Year Operating Plans and the BCF Plans.

CCG 2 Year Operating Plans reflect the BCF schemes for which there is an NHS commissioning lead role.

The planning process for CCG 2 Year Operating Plans and the BCF was originally aligned nationally, with final versions of all plans being required to be submitted by 4 April. However, the BCF planning process is now out of alignment with 2 Year and 5 Year Plans - BCF plans are now being resubmitted with changed metrics. We will continue to refine and amend our plans locally to ensure that they continue to be aligned with the BCF.

Local Authority 2 Year Operating Plans

As part of the Health and Wellbeing Board's statutory duty to ensure that all represented organisations take due regard of the Joint Health and Wellbeing Strategy, the Board conducted an extensive piece of joint work (here) to align all strategic planning across health and social care. The Council's 'Best Council Plan' prioritises the delivery of the 'Better Lives Leeds' plan, including commissioning services to help people stay out of hospital e.g. SLIC, reablement, telecare, and BCF schemes. Key success measures include reducing hospital admissions, bed days, reducing readmissions. It also highlights the need to ensure people have a positive experience of their care, focus on integration of services, the AT hub, CIC bed integration, and the target operating model for integrated HSC teams.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

CCGs have applied for co-commissioning status. Contained within the BCF there are monies set aside to support primary care initiatives in 15/16. We will ensure that as these initiatives develop we will follow the co-commissioning guidance and work with colleagues in NHS England to deliver the schemes.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The health and social care community in Leeds is committed to protect adult social care services. There is an understanding across health and social care partners of the critical contribution that social services make to reducing admissions and re-admissions, reduce delayed discharges and reduce length of stay in hospitals. It is also accepted that a sustainable quality health and social care system can only be delivered within the city where the care is provided in or as close to people's homes as possible and hospital care is only considered when absolutely necessary. It is worth noting that considerable investment has already been made through social services in respect of domiciliary care services, telecare, equipment services and adaptations, together with the support of Neighbourhood Networks, which all aim to help people realise their key outcome of living independently in their own home for as long as possible. Increasingly these services are provided on an integrated basis through partnership arrangements between the Council and the relevant NHS organisations.

Within the above context, our local definition of protecting social care services is to ensure that the above services are maintained, improved, increased and modernised, as appropriate, to ensure that people receive the care and support that they need, in the way that they need it, to achieve their expressed outcomes as independently as possible. In relation to eligibility, there is an expectation that the current FACS (Fair Access to Care Services) levels of eligibility will be maintained in 2015/16 under the new National eligibility framework, detailed by the Care Act (2014), of equivalent to the existing "substantial/critical" thresholds. It is also expected that prevention schemes in Leeds such as the nationally recognised Neighbourhood Networks and other 3rd sector schemes will be at least maintained at current levels. This recognises the critical importance of these schemes to prevent, reduce or delay the need for greater levels of intervention and prevent greater dependency on acute services both in residential and hospital settings. The importance of prevention has been recognised in the Care Act (2014) which will be a mandatory requirement from April 2015.

Our local definition of protecting social services is very much regarded within the context of the Leeds "Better Lives through Integration" programme. This recognises the need to make the most of the Leeds health and social care £ and "wrap" community services (community health and social care services) around the individuals to provide a seamless quality experience. Our whole systems approach includes a number of strands: integrated health and social care neighbourhood teams; single gateway access for professional referrals: an integrated intermediate care and reablement offer and a rapid response service for urgent referrals.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

There is a common understanding within the health and social care community of the very challenging financial context within which adult social care services is required to operate. Notwithstanding the increasing inflation, demand and demographic growth and other pressures being faced by Councils in maintaining Social Care Services, these continue to be experienced within the context of significant ongoing funding reductions for local government. In 2015/16 alone, the above pressures (excluding the Care Act) are currently estimated to exceed an additional £20m, and at the same time there will be an estimated reduction in the local government settlement for Leeds of £46m. This ongoing trend has already led to the proportion of the councils reducing overall budget consumed by Adult social care services increasing from below 30% to 35% over the last 5 years. This clearly impacts upon the ability of the Council to deliver a range of other services, many of which contribute to the positive Health & Wellbeing of all Leeds citizens.

The Council has once again demonstrated its commitment to Adult Social Care Services by requesting that they make a contribution of less than £4m to meeting the £46m overall funding reduction. Whilst there is a commitment for Adult Social Care to meet that funding reduction, together with inflation and other pressures through their ongoing 'Better Lives' and other efficiency programmes, the demand and demographic pressures cannot be met through these measures. At the current time these demand and demographic pressures are estimated by the Council to be in the region of half of the total pressures outlined above. Discussions continue around how this gap, within the context of other pressures and gaps amongst Health Partners, can be closed through the best collective use of the Leeds £.

The approach to the use of the Better Care Fund in Leeds has been to free up resources for invest to save proposals to support the delivery of a high quality and sustainable health and social care system for the future. It has not been our approach to utilise this investment to meet current demand/demographic pressures and funding reductions experienced by Social Care. Nevertheless, there is both a recognition of the significantly adverse impact that failure to protect social care services in Leeds would have on the stability of the whole Health & Social Care economy in Leeds, and a long standing commitment from Health Commissioners to support the Council in protecting social care services where practicable through the better use of resources outside of the Better Care Fund.

However, there is also a recognition that there are significant financial pressures across the whole health and social care economy at a time when the CCG allocations have been subject to reduced allocation growth as part of the national "Fair Shares Process" in 2014/15 and 2015/16, with even greater uncertainty moving beyond this time frame.

The local schemes and spending plans will also support the delivery of planned savings in Adult Social Care expenditure. In particular, a number of the schemes will continue to contribute to the ongoing reduced trajectory in relation to the consumption of residential care bed days, delivering a projected saving of £1.3m in 15/16. The further development of the reablement service will also support delivery of planned savings of £0.2m in 15/16 and £0.3m in 16/17, over and above the significant savings already achieved through this approach.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The indicative amounts set aside from the Better Care Fund to protect social care services include £12.5m as part of the existing £1.1bn transfer from the NHS to social care in 14/15. £11.8m of further ongoing support for reablement (£2.8m), Carers (£2.1m), Equipment (£2.3m), 3rd Sector Support (£4.6m) provided predominantly for working in partnership with other organisations that benefit health services in Leeds.

Individual schemes within the BCF will also support the delivery of additional social care services where these deliver an additional health benefit, such as the move to 7 day working in the Leeds Community Equipment Service. In addition, where there are direct costs for social care arising out of schemes, such as additional home care support, these have been factored in, where known, in individual schemes.

In respect of the £135m national allocation, we can confirm that a provisional non-recurrent allocation of £1.9m (revenue) and a £0.7m of (capital) has been identified within the Leeds BCF to meet the additional burdens and responsibilities arising from the Care Act (2014). It is important to note the uncertainty around activity levels (especially numbers of people presenting needs) and the resulting likely spend arising out of implementing the Care Act reforms from 15/16. This represents a potential significant risk to the sustainability of Health & Social Care in Leeds, and this risk would need to be managed within the overall context of the vision for Leeds and the Leeds £.

The Care Act (2014) reforms represent a generational change in social care services and will introduce a number of new legal duties and responsibilities. These will include: national eligibility and assessment framework; prevention; carers' entitlement to assessments and services; personalisation, market shaping and oversight; advice and information and duty to promote integration with health partners.

The reforms are being overseen by the Care Act Programme Board (CAPB) which is a multi-agency forum chaired by the Director of Adult Social services. Adult social services and its key partners in health and the 3rd sector (such as Carers Leeds) oversee a number of workstreams including: Assessment and Eligibility; Carers; Advice and Information; Consultation, Engagement and Communication and Information, Management and Technology. It is the role of these workstreams to articulate at an operational level what the requirements of the Care Act (2014) are and set out options for the re-design of key local services. It is expected that these workstreams will report their options for changes to the CAPB in October/ early November. Proposals for new service developments will also be reported to and considered by key strategic forums such as Adult Social Services Leadership Team, Integrated Commissioning Executive (ICE) and the Leeds Transformation Board. This approach will also ensure that the interdependency between the BCF and the implementation of the Care Act (2014) will be closely monitored to ensure that funds allocated deliver agreed outcomes. As the Leeds health and social care community moves from planning/ options appraisals to implementation, the Health and Wellbeing Board and the Council's Executive Board will also play an active role in ensuring that the reforms are successfully implemented in Leeds.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

It is not possible at this stage to set out in detail how the duties and responsibilities in the Care Act (2014) will be met. As highlighted above, the Care Act (2014) programme is currently in its planning/options appraisal stage. Work is ongoing to articulate the requirements of the Act and in particular, to determine the costs/ funding implications. Detailed options for service developments resulting from the Care Act (2014) are scheduled to be presented to CAPBM and key strategic groups and forums in October/November.

v) Please specify the level of resource that will be dedicated to carer-specific support

The Leeds health and social care community has an excellent record in supporting carers across the city, however through extensive consultation with Carers we are aware of areas where we wish to focus on improving. This includes flexible and consistent access to a range of respite care, quality information, support through the complex health and care system, tackling the financial hardship that can be brought upon by the caring role; and recognition of the role of Carers as vital partners across all organisations supporting the cared for person. £2m will be allocated to support carers' breaks and other support services in 14/15. Scheme 3 of our plan to support for carers, sets out support arrangements for people with dementia, those who have recently been bereaved and respite opportunities (both residential care and in people's own homes).

Looking forward to 15/16, an additional £500k has been provisionally allocated to carers within the BCF. It is intended to focus this on the areas such as respite outlined above. However early estimates indicate that from 2015, a further £3m will be required to fund strengthened entitlements to carers assessments (£420k) and ensuring support packages (£2.5m) which were established by the Care Act (2014). This cost estimate assumes that an additional 11% of carers who are currently unsupported (56,000) will approach the Council for additional support.

A range of services for carers that are currently commissioned by health and social care partners will continue to be supported. Current information from the monitoring and evaluation of these services has informed the BCF plans, backed by the aspirations of the Leeds Carers Strategy. Following a review of carer support arrangements, Carers Leeds are now established as the single point of access and referrals for a number of organisations such as Alzheimer's Society (Dementia Carer Support), Touchstone (BME Carers), Age UK (older carers) and Leeds and York NHS Partnership Foundation Trust (Carers of People with Mental Health needs). These commissioned services aim to improve the health and wellbeing of carers (including young carers) so that they are able to continue with their responsibilities and avoid a breakdown of carer arrangements. The latter can often lead to hospital admissions of the cared for person. Specific Carers Services include: a Carers Emergency Plan scheme (which seeks to replace a family carer for up to 48hours, thereby avoiding emergency admissions); A Young Carers Service; Carers Information Service; Carers Sitting Services and the promotion of health checks for Carers.

All GP practices in Leeds are also now signed up to the "yellow card scheme" which

identifies carers and refers them to Carers Leeds for information, advice and support. These schemes recognise the critical role that carers play in helping people with health and social care needs to live as independently in their own homes for as long as possible. This in turn, reduces the risk of a breakdown in carers' arrangements. These carer support arrangements demonstrate positive impacts on patient level outcomes

See appendix 8 and 8a for a copy of the Carers Strategy

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The main changes are that demographic and other pressures on ASC have increased since the initial submission and the Council's draft allocation of available resources to ASC is greater than previously identified, however it still leaves a significant shortfall in the necessary resource required to protect social care services. As outlined within the contingency section of this submission, the changes to the pay for performance element within the BCF, requires a £2m contingency to be maintained specifically to remove risk from the non-achievement of the reductions in acute admissions. This will effectively limit the local flexibility available within the fund and increases the risk for all community based services, including in relation to the protection of social care services.

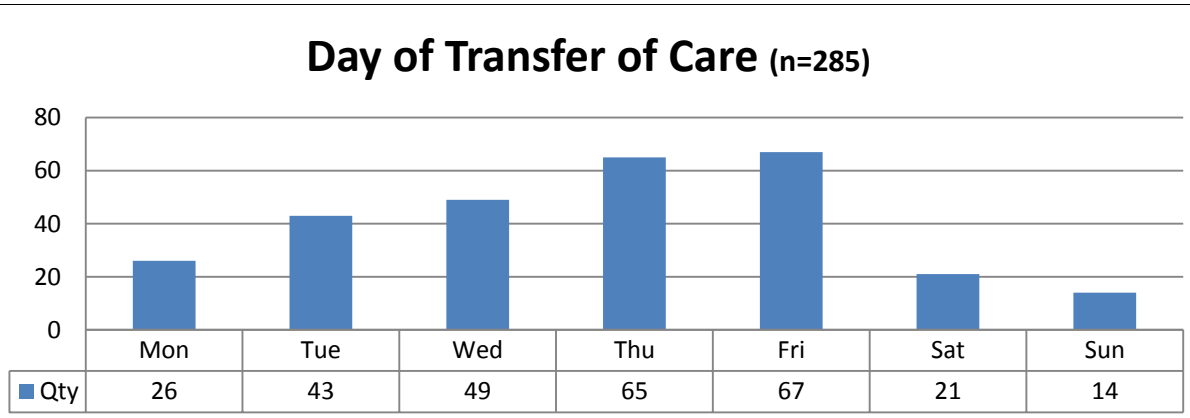
b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Background
Moving health and social care services from five to seven days is a key commitment across the Health and Social Care system. The day of the week on which a person becomes ill (or recovers from illness) should not be the determinant of the services that someone can receive, or the speed with which they can access services or return home.

This commitment to 7 day services is a core requirement of the 14/15 contract with all main NHS providers, and the health and social care economy will need to work together to facilitate the delivery of seven day working requirements.

Current challenges in Leeds
The chart below shows the result from a recent audit of patients from the hospital elderly medical wards showing the day of the week a transfer of care occurred. Working in this way increases pressure on community and social care services at the end of the week, and means that patients remain in a hospital bed (often unnecessarily) over the weekend as either the hospital is not set up to discharge or services are not available to support patients in the community over the weekend.



As a city, our aim is to smooth out this graph by reducing the peaks and troughs seen here throughout the week. Having services available consistently will reduce length of stay and reduce the pressure points on services at certain times of the week. In the example above this should impact positively on discharge arrangements, but there will be other services too which will impact on admission avoidance.

Action plan for 2014/15

Leeds has already started on its journey to deliver seven day services in the city. We already have a 24/7 community nursing and care management service. There are plans in some parts of the city to further develop primary care services to improve access to GPS at weekends and in the evenings. The BCF offers the city an opportunity to build on this.

The action plan in 14/15 requires fundamental and large scale change to existing services and we see the BCF targeting seven day working – particularly in relation to community beds and enhance integrated neighbourhood teams schemes. Operational changes that are due to come online during the course of 14/15 include:

- The community bed bureau would become a seven day service
- The Homeless discharge service would be available seven days a week
- Leeds equipment service being available seven days a week
- The early discharge assessment team, based in the hospital A&E department will maintain the service that operated over winter, including seven day working
- Fund extra discharge facilitation roles to work on a seven day basis
- There will be a seven day community nursing service to support patients choosing to end their life at home and new nurse-led beds in the community
- Extend the home care service to deliver 24/7 support for service users

This will allow out of hospital services to better respond to the anticipated increase in transfers of care at weekend from hospitals. There is a breadth of schemes that will impact on both admission avoidance at the front door of A&E and support discharge processes and reductions in length of stay. Many of our delays in the city at the present time relate to medically fit patients sitting in beds, over the weekend who cannot be moved on to another provider or to home until Monday. Schemes and plans for 14/15 will start to address this issue.

All of these services will be funded from BCF initiatives and schemes.

Future plans

Further work following submission to develop detailed implantation plans for the BCF will

involve taking into account the cost of moving to seven day service and equally the potential savings from operating uniformly during the week. Detailed plans for 15/16 and 16/17 for seven day working arrangements are currently being agreed. These plans will need to include not just funding and schemes from the BCF but other contractual and organisational changes.

The main risk to delivery of 7 day services relate to costs. Moving to a seven day service is not simply about replicating what we have in the week at weekends. We also need to address rotas and change service models across health and social care to facilitate this. This detailed work is underway at the present time.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

As an integration pioneer with an excellent track record in informatics, Leeds is leading a collaborative of Pioneers through the SOCITM network and ADASS to look at shared barriers and blockages to data sharing. This has led to close working with the DH to look at how national legislation can improve data sharing, for examples, the recent section 251 application being pursued for risk stratification using health and social care data.

Leeds is modelling its innovative practice in this regard which will be shared with other areas, for example, further development of the Leeds Care Record. This is also forming one of our Tech Fund applications to enable further implementation. This system allows all relevant practitioners within the system to see real-time data on individuals at the point of service delivery. This work has been piloted in 60 GP practices and would not have been possible without Leeds' commitment to use of the NHS Number. The Leeds Care Record is built upon a data sharing agreement that has sign-up from the acute hospital, GP Practices and the Local Authority.

The NHS Number is being used as the primary identifier across health and social care (key systems across the health and social care system can handle the NHS number) and NHS numbers are 'traced' and added to the patient/client record as early as possible. However, the acquisition of NHS Numbers in social care is via a tactical (non-strategic) solution and further work needs to be done to use the NHS Number within social care correspondence.

Significant work has been completed to enable e-correspondence, which automatically includes the NHS number. This includes e-Discharge letters, e-Test Requesting, e-Results and Radiology reports, e-Discharge Initiation Documents. Within the proposed BCF Informatics scheme is the work to extend e-correspondence to outpatient letters and A&E attendances and then subsequently make visible all secondary care correspondence via a Leeds Care Record.

Within the proposed BCF Informatics scheme is the work required to deliver a strategic solution to obtaining the NHS Number for social care using the national Patient Demographic Service (PDS). This work will commence in 2015/16, as part of our work to

go “further and faster” towards integration. Alongside this is resource to embed the NHS number in to social care correspondence within that time frame.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Adopting systems that interoperate is a key part of a formal Leeds-wide Informatics strategy and progress is being made towards delivery. We have strong examples of where the ITK has been used, though there is some dependency on large national system suppliers such as TPP. Leeds is committed to work with Open APIs, however, cost is a factor and the cooperation of system suppliers is required. Open APIs support the integration of systems and data and this is a key part of the Leeds Informatics strategy. It is a strategic intention and direction of travel; a timeline and investment plan is in development.

Currently Social Care, CCGs, GPs, Community and Mental Health organisations are using secure email. The acute hospital is at the early stages of implementing NHS Mail with considerable progress expected during 2014/15.

As part of its wider ambition to become a digital city, Leeds is focussed on adopting the Public Sector Network as the technical infrastructure to support health and social care integration. Together with the necessary platforms for technology to support self-care and self-management, “big data” solutions will support more accurate commissioning and service provision decisions in line with people’s experiences of care – which will lead to better outcomes for the people of Leeds. Additionally, the establishment of an ‘interconnect’ with the existing NHS network (N3) enables much of the local aspiration to be achieved.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

We are committed to ensuring that the appropriate IG controls are in place. All individual health and social care organisations are operating at Level 2 against the IG Toolkit. We are working closely with HSCIC DSCRO to ensure that data flows are in line with Caldicott 2 and have a number of data sharing and data processing agreements in place. Of particular note is the recent multi-party data sharing agreement to support the Leeds Care Record. All 3 CCGs have also signed-off the NHS England Risk Stratification assurance statement.

However, there are acknowledged challenges around delivering IG for integrated working, especially shared data, shared systems and common care processes. Therefore, within the proposed BCF Informatics scheme (scheme 19) is the resource required to strengthen the city-wide (multi-organisational) IG expertise. As an Integration Pioneer city we are working with our pioneer colleagues to raise the visibility of IG issues nationally and have participated in the recent section 251 application being pursued for

integration and the use of health and social care data in areas such as caseload matching.

Leeds is also leading national work to develop a Public Services-wide IG Toolkit which rolls out in 2014, with a fully rationalised version completed in 2015. This work underpins health and social care transformation locally and nationally.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

In Leeds, the risk stratification tool has been rolled out across primary care, and is also available to some of the integrated neighbourhood teams. The teams that do not currently have access to the tool will be granted access over the course of 2014/15. This will ensure a common way in the city of assessing the risk of hospitalisation for patients. At the time of writing, the risk stratification tool indicates that 2.6% of people in the city are at high risk of admission to hospital.

Leeds' innovative work on information governance and data sharing (as outlined earlier in this template) has enabled us to go so far in this regard. A Joint Gateway has been developed to enable health and social care professionals from different organisations to work more effectively. The Leeds Care Record has already been rolled out to a number of GP practices and can be accessed by Adult Social Care staff. However, there is still more work to do and the intention is that our Pioneer status enables us to move forwards, with national support, over the lifetime of the BCF.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Leeds has a well-established system of risk stratification already in place to identify patients at high risk of hospital admission. The system supports accountable lead professionals to work in a more proactive and preventative way, identifying patients before they become unwell and ensuring they have a tailored care plan in place.

The introduction of new arrangements for GP contracting this year provides an opportunity to adapt the way in which the tool is used. The tool will be used to identify the top 2% high risk patients from each practice and from that will include the development of a care plan. The plan will identify a named accountable GP within the practice who has responsibility for the creation of each patient's personalised care plan. In addition, the plan will also specify a care co-ordinator, who will be the most appropriate person within the multi-disciplinary team to be the main point of contact for the patient or their carer to discuss or amend their plan. This could be the GP or it could be another member of the integrated neighbourhood team. This process will ensure MDT input into care, coupled with professional accountability.

To support risk stratification and motivate further joint working, a complimentary CQUIN came into effect on April 2014. The CQUIN incentivises Leeds community health services

to work in a more interdisciplinary way with primary care, to deliver improved proactive care management. The first quarter has seen close working between all 3 CCG's, their member practices and Leeds Community Healthcare to determine future roles, responsibilities and working practices.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Work is on-going to ensure each GP practice in Leeds has in place care plans for the top 2% patients by risk. In addition, as part of integrating health and social care services in Leeds increased focus is being placed on ensuring joint care plans are in place. As part of BCF work programme, further work is planned to link and align care planning systems across care sectors to move toward a single care planning process.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

BCF engagement

Following on from the submission of the first draft of the BCF, HealthWatch Leeds has led a rapid consultation with the public, using both face-to-face and social media approaches, to test out and support further development of proposals. The results of this consultation tell us that, overall, the proposals set out for Leeds' Better Care Fund were supported. A number of proposals particularly resonated, including Eldercare Facilitators, Enhancing Integrated Neighbourhood Teams and reducing emergency admissions through a case management approach to urgent care. Other findings on the proposed schemes will be used to inform development work going forwards. The full findings are attached at appendix 4.

A more in-depth consultation process with service users/patients on an individual scheme basis (where appropriate) is anticipated for later in 2014/early 2015. This will shape and develop the detail and delivery of the new schemes and will be aligned to transformation work. In particular, engaging with service users/patients will play a key role in the scoping and development activity we will be funding through identified "pump-priming" monies in 2014/15.

Ongoing engagement

In terms of the wider context of our plans for integrated care in the city within which the BCF sits, patients, service users and the public have played, and will continue to play, a key role in its development. Building on the National Voices consultation, local patient/service user voices of all ages have been used to frame the Leeds vision for person-centred care:

"Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect".

Our Charter for Involvement in Integration (see below and appendix 9) was co-produced with people who access services and their carers , it includes a clear expectation that the views of people who use services will be integral to the reshaping of those services, and we are committed to providing feedback on how those views have been incorporated into our plans.

Charter for Involvement in Integration

The Charter is a clear set of statements by people in Leeds with long-term conditions and carers about our expectations for involvement in Integration. It brings together people's views and needs, making clear what we want from integration and how other people can help achieve this. Changes that follow this statement will support what we want for the future and our lives. Effective Integration in Leeds needs:

- Genuine involvement that is demonstrated by views being heard, not just the opportunity to raise them.
- To adhere to high standards / good practice in involvement, ensuring lots of varied opportunities for people to be involved in a meaningful way, whatever our level of skills / confidence / understanding of the issues.
- To take into account what's already been asked… and answered
- Involvement that reinforces what people find valuable in being involved, that it makes a difference.
- Involvement that includes people with long-term conditions and their family / friends carers, where appropriate separating out different agenda / views.
- Involvement with existing groups / networks so that information can effectively be cascaded by them and views sought from particular groups of people via those networks
- Involvement of voluntary and community sectors supporting older people, and specialist organisations supporting people with a particular long-term condition, but not using this to replace the direct voice of individuals with long-term conditions
- People with long-term conditions involved in every part of the work at every level, with people on Boards acting as a conduit for wider views into the project.
- To recognise the many calls on people's time, developing different ways for people to be involved and avoid duplication / clashes in other involvement activity and commitments / caring responsibilities.
- Feedback from involvement and the opportunity to add more as people think of it
- To model good practice and promote the Dignity agenda to improve standards of care more generally

To make this real, I/we will .....

.....

Name: .....Date: .....

Agreed by Integrated Adult Health and Social Care Board 30.5.12

In line with the Charter, patients and service users are already involved in designing services and shaping change through patient advisory and liaison groups and representation on boards and steering groups. Additionally, staff groups across health and social care have also been involved from the beginning in the development and implementation of our plans for integrated services. The Integrated Teams are also using a Leeds University developed service feedback process whereby trained volunteers interview patients and their comments are then used to inform future service improvements.

Finally, the NHS Call to Action and development of our 5 year CCG strategy has provided us with an additional platform to further strengthen our engagement with the public more broadly. The concept of investing in social care and integrated care to reduce demand on urgent and acute care is being promoted in the city and is actively discussed at patient and public forums.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

BCF engagement

This plan has been jointly developed by all of the health and social care organisations (including both statutory and third sector providers) across Leeds that work to deliver outcomes for the Leeds Joint Health and Wellbeing Strategy and thus link into the Leeds Health and Wellbeing Board.

The development of the BCF plan has been led by the Integrated Commissioning Executive. It has been developed through a series of BCF-specific, well-attended workshops with attendance drawn from provider and commissioning organisations from across the city. It has been supported by a number of existing boards, aligned to the Health and Social Care Transformation Programme Board, which have senior representation from all service provider organisations.

As well as senior representation, membership also includes frontline staff from medical, nursing and mental health backgrounds, third sector representatives, patient and carer representatives, other health and social care professionals, and colleagues from Public Health.

Since the first draft was submitted in April, there has been further consultation with providers:

- Series of meetings between CCG lead officer for the BCF with NHS provider chief executives
- Presentation to and discussion at the Directors of Finance forum, aligned to the Transformation Board –opportunity to further focus on quantifiable savings and financial impact on the provider landscape and agreement to jointly sign off the schemes through the detailed business case and implementation phase
- As part of the “exemplar” submission process in July, there were a further series of meetings with providers focussed specifically on the BCF submission. We now have representation from providers on the BCF task and finish group, and as of October they will be represented at the HWBB.
- Establishment of BCF Metrics/Intelligence group which has representation from Leeds Teaching Hospital Trust and Leeds Community Health Trust.
- Broadening of the BCF Task & Finish Group to include representation from Leeds Teaching Hospital Trust and Leeds Community Health Trust.

We have also consulted with Leeds City Council’s Executive Board and Health and Wellbeing and Adult Social Care Scrutiny Board on the BCF submission.

Ongoing engagement

In addition to the specific work to develop the BCF, for the past three years, Leeds has

operated a Health and Social Care Transformation Board that comprises the Chief Executive (or equivalents) from all of the city's commissioner and provider bodies, plus third sector representation. Additionally, we are dedicated to maintaining parity of esteem between physical and mental health services.

Significant engagement work has been completed in Leeds CCGs in primary care to engage with them on the urgent need to transform services. Applications to the Prime Minister's Challenge Fund have included additional funding requests to extended and out of hours services, provide flexible access to clinicians via technologies such as Skype, better joining up of urgent care and out of hours care and improved access to telecare so people can live for longer in their own homes. Continuing to roll out new technologies with primary care forms part of the "enhancing primary care" scheme of our BCF.

Additionally, we are committed to clinical leadership and engagement across all sectors. In secondary care, the CCGs are working with acute hospital consultants and the local clinical senate to look beyond our shores at models of healthcare overseas, at the Intermountain Healthcare organisation in Utah, United States. Through this continued work, our aim to bring back to Leeds the best examples of good practice and innovation and this will continue to inform the schemes of our BCF.

ii) primary care providers

As above

iii) social care and providers from the voluntary and community sector

In addition to information covered in previous sections of this submission we have undertaken:

- Consultation event with over 25 members of Healthy Lives Leeds, the 3rd sector representative collaborative.
- Adult Social Care's Directorate Leadership Team (DLT) and Departmental Senior Management Team (DSMT) have been consulted at various stages of the development of the BCF through presentations at the DLT and DSMT as well as having representation as part of the BCF Task & Finish Group.
- All of this is underpinned by extensive consultation, engagement and co-production with service users, carers and citizens

This takes part in regard to the BCF within 4 levels:

1. Ensuring we take heed of previous consultations. Service users and carers have expressed their frustration at being asked the same questions over and over again, especially where they do not see any change, or even get feedback as to what their contributions resulted in. We have therefore in relation to each scheme and the overarching 'direction of travel' within the BCF made extensive use of previous engagement activity. For example, the proposals in regard to dementia services come directly from the priorities within the Leeds @Living Well with

Dementia strategy, which was produced via a series of major public events, meetings with people with Dementia and their carers and specific feedback from groups such as the Leeds Dementia Peer Support group and organisations with a strong user voice such as the Alzheimer's society and Leeds Older People's forum. Similarly, we have used the extensive consultation with Carers on the Leeds Carers Strategy – to be published later this year – to inform the proposals around Carers. This consultation included distribution of thousands of questionnaires, backed up by focus groups and again attendance at meetings, supported by Leeds Carers Association.

2. Engagement of service users throughout the entire commissioning or service transformation process. For example, the proposals around Homecare have arisen out of the wider engagement on the delivery and re-commissioning of Homecare in the city. For this process, all users of ASC's contracted home care services (over 2,340) were invited to participate in the process. We also contacted other groups who we felt would particularly want to contribute; these included disabled people, older people and people from BME communities. To ensure effective engagement, people were offered different methods to gather their views From this:
    - A small group of users, supported by an independent User organisation, joined the Strategic Home Care Advisory Group chaired by the Lead Member for Adult Social Care
    - Face-to-face discussions with 15 service users on a 1-1 basis, took place and over 40 people in focus groups.
    - A survey of service users and carers which was completed by 79 users

The information from this consultation has been used to inform both the BCF and ASC and CCG Commissioning plans for Homecare.

3. Engagement with strategic boards with oversight of particular work streams
   Each of the schemes can be placed within an existing commissioning/service transformation framework. For each of these there is strong service user engagement in the decision making processes. For example, there has been a long standing Community Equipment Board to oversee the development and running of the service. This has always had strong user membership, again supported by an independent user support organisation. This in turn is supported by an equipment user reference group, which meets on its own and comments both on the day to day running of the service, as well as ambitions and aspirations. That group has identified the need to expand the service to 7 day working, as well as the work to develop a 'one stop shop' for equipment services.

   Similar, other strategic Boards have both individual representatives from the relevant service area; Carers, Homecare Users, MH service Users, people with Learning Disabilities etc. as well as representatives from User organisations such as Leeds Older People's Forum, Carers Leeds, and People First etc.

   Others, such as the 'Better Lives Board' have a wider focus in regard to their areas of responsibility, but an even stronger user voice. The Better Lives Board is Chaired by the Lead Member for Adult Social care and is attended by senior ASC officers, but the majority of the membership are service users, recruited from a range of user groups in the city. Officers are summoned to the Board to outline any major service transformation or commissioning plans and the board acts as a

form of service user scrutiny for these. The Board has also identified its own priority areas and ASC plans now need to reflect these. These have included identifying and deciding the Equality Markers within ASC. The Board has had presentations on the BCF and on particular schemes and their views on these have influenced the nature of the schemes. As these develop, this will be fed back into the Better Lives Board.

These Boards also engage with wider groups of service users, carers and wider community when looking to develop services further, such as the schemes in the BCF. This is done largely in partnership with organisations such as Leeds Involving People and Healthwatch Leeds and uses a variety of consultation methods, as outlined in the Homecare example above.

4. Citizen engagement

It is also important to hear the wider voice of citizens in Leeds, and also to ensure that work is led by that voice, not just 'us consulting with them'. There are a number of routes to do this, but at the heart now is the role of Healthwatch Leeds. They directly gather the views of service users, patients, carers and citizens as a whole and feed these into commissioning and service transformation. This includes directly into the Health and Well-Being Board but also by regular meetings with Commissioners where they can identify core issues they have picked up from their extensive consultations (events, questionnaire, Social Media, Meetings, their members/volunteers) and we can use these to inform our commissioning plans, in this case to assist in the prioritisation of the various submissions to the BCF.

It is also important to recognise that none of the above are one off processes. We continue to sustain and support engagement and a key element of the BCF plans will be to feedback to these groups, to ask them to take part in evaluation and to use this to develop work further

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

One of the two key elements of Leeds Teaching Hospitals NHS Trust's (the Trust) strategy is to achieve high quality integrated care in conjunction with health and social care partners in Leeds. The aim of this strategy is to care for each patient in the most appropriate environment and to make the best use of each organisation's resources and expertise. The Trust has therefore been an enthusiastic participant in the Leeds Transformation Programme since its inception. It has active representation on the Programme's four work streams and is committed to deliver seamless integrated care across organisation boundaries. Three of the four transformation groups link to the BCF including improving pathways and reducing urgent admissions for patients such as the frail elderly and those with long term conditions (the fourth Transformation Programme being elective care). In order to deliver care in the most appropriate environment, it is

recognised that there is a need to reduce some of the care that these patients' currently receive in the acute sector and provide more integrated care in the community.

The second key element of the Trust's strategy is to provide specialist care for patients drawn from across Yorkshire. The work of NHS England in improving and streamlining specialist services will affect the range and volume of services that the Trust will provide over the medium term. The Trust will ensure that this will not be to the detriment of the work that it is asked to deliver for Leeds patients (including specialist work) which will be discussed with commissioners and health partners across the city. This will include developing the Trust's capacity and workforce plans with other agencies to take account of the changes to specialist services provision and the enhancement of community provision as a result of the BCF and the Transformation Programme.

With regard to risk, if BCF and Transformation schemes fail to reduce hospital acute admissions the principal financial risk lies with our commissioners. The Trust however faces additional risks itself, particularly if bed capacity is removed before the schemes have proved successful. These risks include:

- The need to reopen capacity at short notice with premium costs incurred to secure medical and nursing cover,
- A reduced bed base which no longer has the capacity to cope with demand for hospital admissions, threatening elective care targets,
- Pressures in A&E compromising the 4 hour waiting time target.

All health and social care organisations in Leeds face a substantial financial risk of unsustainability. The Trust is required to produce efficiency savings in excess of £50m in 2014/15 and in line with national efficiency requirements thereafter and the Leeds health economy has a financial challenge of over £100m a year.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

Please see attached scheme business cases/descriptions.

It should be noted that 2014/15 is being used as a shadow year to "pump prime" the Better Care Fund proposals. As the BCF does not come into being until 2015/16, in 2014/15 the funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year.

Many of the "pump-priming" schemes have been allocated funding in 2014/15 to scope and develop robust business cases that will evidence, as far as possible, return on investment, anticipated shift in activity and impact on the acute sector. Locally, "pump-priming" funding was identified for 2014/15 through non-recurrent monies.

This approach effectively allows us to us to test out assumptions, develop robust and accurate evidence of benefits and provide an agile and flexible response to the key question of "is this individual scheme working for Leeds?". This will also allow us to further develop schemes proposed for 2015/16 and take forward pilot schemes from 2014/15 which have evaluated successfully as well as test out governance and programme management arrangements.

Equally, it will be essential to establish whether schemes funded in 2014/15 will be able to demonstrate a return on investment before further funding is released for 2015/16 and this will be closely monitored. This is so we can accurately model and monitor once the BCF goes live in 2015/16 and ensure we are investing the full fund into the right schemes that will meet our objectives. If schemes cannot demonstrate a return on investment through the business case development phase, they will be withdrawn from the BCF.

As the schemes are rolled out it anticipated that the they will continue to realise benefits past 15/16 with some of the benefits being reinvested to fund successful schemes in subsequent years.

It should also be noted that between September and December '14, Leeds is undertaking a review of all business cases in-line with the approach described in section 4 of this narrative submission. Where appropriate, business cases will be further refined to ensure that they meet the national scheme business case standard.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Leeds Health and Wellbeing B
Name of Provider organisation	Leeds Teaching Hospital NHS Trust
Name of Provider CEO	Julian Hartley
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	66,265
	2014/15 Plan	66,118
	2015/16 Plan	64,911
	14/15 Change compared to 13/14 outturn	- 147
	15/16 Change compared to planned 14/15 outturn	- 1,208
	How many non-elective admissions is the BCF planned to prevent in 14-15?	680*
	How many non-elective admissions is the BCF planned to prevent in 15-16?	590

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust can confirm that the overall quantum of change is in line with previous discussions, recognising that scheme development is not yet sufficiently progressed to quantify the impact of each individually.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust understands the overall objective and impact of the BCF programme and recognises it as an important component in improving services within Leeds and achieving financial sustainability. However, the schemes have not yet been modelled at a sufficiently granular level to determine the precise implications.

Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Leeds

Please provide:

Manraj Singh Khela
manraj.khela@leeds.gov.uk

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Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Leeds

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	67,327
Change in Non Elective Activity	-2,357
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	5,067,550
Combined total of Performance and Ringfenced Funds	14,485,838
Ringfenced Fund	9,418,288
Value of NHS Commissioned Services	34,104,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	17,680	34,111	50,716	67,327
Cumulative Change in Non Elective Activity	-354	-847	-1,511	-2,357
Cumulative % Change in Non Elective Activity	-0.5%	-1.3%	-2.2%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	761,100	1,059,950	1,427,600	1,818,900

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Health and Wellbeing Funding Sources

Leeds

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	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
Leeds	5,000	4,802
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
Total Local Authority Contribution	**5,000**	**4,802**
CCG Minimum Contribution		
NHS Leeds West CCG		20,105
NHS Leeds South and East CCG		17,351
NHS Leeds North CCG		12,665
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**50,121**
Additional CCG Contribution		
<Please Select CCG>	**2,759**	
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**2,759**	**-**
Total Contribution	**7,759**	**54,923**

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Summary of Health and Wellbeing Board Schemes

Leeds

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Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	12	2,800			
Mental Health	59	885			
Community Health	12	8,483			
Continuing Care	-	-			
Primary Care	-	2,141			
Social Care	-	18,019		26,900	6 NHS E s256 £12.5m, Reablement £2.8m, Carers £2.1m, equipment £
Other	1,392	22,595			
Total	**1,475**	**54,923**		**26,900**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure
	2015/16
Mental Health	885
Community Health	8,483
Continuing Care	-
Primary Care	2,141
Social Care	-
Other	22,595
Total	**34,104**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	86	1,570	
Increased effectiveness of reablement	-	-	
Reduction in delayed transfers of care	296	2,551	
Reduction in non-elective (general + acute only)	740	4,958	5,068
Other	-	99	
Total	**1,122**	**9,178**	**5,068**

place in the city, that sit outside the BCF that we are assured will mean we will achiev

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Health and Wellbeing Board Expenditure Plan

Leeds

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
Reablement services	Other	Social and Community Health	CCG			Local Authority	CCG Minimum Contribution		4,512
Community beds	Community Health		CCG			Local Authority	CCG Minimum Contribution		5,300
Supporting carers	Other	3rd Sector and voluntary	CCG			Local Authority	CCG Minimum Contribution		2,059
Leeds equipment serivce	Other	Social and Community Health	CCG			Local Authority	CCG Minimum Contribution		2,300
3rd sector prevention	Other	3rd Sector	CCG			Charity/Voluntary Sector	CCG Minimum Contribution		4,609
Admission avoidance	Acute		<Please select>			NHS Acute Provider	CCG Minimum Contribution		2,800
Community matrons	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		2,683
Social care to benefit health	Social Care		<Please select>			Local Authority			12,417
Disabilities facilities grants	Social Care		<Please select>			Local Authority			2,958
Social care capital grant (care bill)	Social Care		<Please select>			Local Authority			744
Enhancing primary care	Primary Care		CCG			Primary Care	CCG Minimum Contribution		2,141
Eldercare facilitator	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	47	565
Medication prompting (dementia)	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	12	320
Falls	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	12	500
Expand community intermediate care beds	Other	Social and Community Health	CCG			NHS Community Provider	CCG Minimum Contribution	248	1,490
Enhancing integrated neighbourhood teams	Other	Social and Community Health	CCG			NHS Community Provider	CCG Minimum Contribution	304	3,590
Urgent care services	Acute		CCG			NHS Acute Provider	CCG Minimum Contribution	12	
Information technology (inc. social care capital grant)	Other	Health and social care	CCG				CCG Minimum Contribution	800	1,800
Care bill	Social Care								1,900
Improved system intelligence	Other	Health and social care	CCG				CCG Minimum Contribution	20	80
Workforce planning & development	Other	Health and social care	CCG				CCG Minimum Contribution	20	80
Contingency fund	Other	Contingency	CCG				CCG Minimum Contribution	-	2,075
Total								**1,475**	**54,923**

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Health and Wellbeing Board Financial Benefits Plan

Leeds

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		15 a: Expand community Intermediate Care beds	NHS Commissioner			-	Due to lack of available beds, it is estimated that 420 patients who could have been diverted from A&E into a CIC bed end up being admitted to hospital non-electively each year. By adding capacity to the system and re-designing the pathway this initiative is anticipated to avoid these admissions. This scheme is due to be implemented in Oct-2014.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		16 f: Enhancing Integrated Neighbourhood Teams	NHS Commissioner			-	Increasing nursing capacity in the community is expected to allow between 300 and 500 more patients each year to choose to die at home rather than in hospital. Using NICE System Impact Modelling End of Life Tool, this additional support is expected to avoid 340 non-elective admissions. This figure is consistent with local intelligence for the opportunity saving associated with avoided non-elective admissions. Plans are in place to start implementation in Jan-2015, with the bulk of the impact being realised in FY15/16.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		12: Eldercare Facilitator	NHS Commissioner			-	Target to increase the number of dementia patients (at any point in time) who are known to primary care by 1,400 (by the end of FY15/16), of which 500 will likely fall within the 2% @ risk cohort. Accounting for churn in the populations (dementia patients have relatively short life expectancies), by identifying new dementia patients and putting care plans in place it has been estimated that 100 admissions to hospital will be avoided. Current plans for for this service model to be in place by Jan-2015, with the bulk of the impact being realised during FY15/16.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		16 e: Enhancing Integrated Neighbourhood Teams	NHS Commissioner			-	By targeting this intervention at patients with a high risk of admission to hospital in the next 12 months, there is an expectation that this risk will be mitigated, reducing demand for non-elective care. A small scale pilot supports this hypothesis, and current plans are to make this service available to between 1,000 and 1,200 patients each year. Assuming these patients see their risk of admission to hospital reduce by 10% on top of the impact factored in for care planning - see Scheme 11), this is expected to reduce non-elective admissions by between 70 and 84 per year. A phased roll-out in planned for Jan-2015, with the service reaching full capacity in early FY15/16.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		15 d: Expand community Intermediate Care beds	NHS Commissioner			-	By case managing homeless patients on discharge from hospital there is an expectation that re-admissions to hospital for this cohort will be reduced. Assuming a 20% reduction in re-admissions, this equates to 41 avoided admissions per year. This service is expected to go live in Jan-2015.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		15 b: Expand community Intermediate Care beds	NHS Commissioner			-	Moving to seven day working is expected to facilitate more CIC bed placements at weekends, offering efficiencies in terms of how the CIC bed estate is used. This may be expected to translate into more patients being diverted direct into a CIC bed, avoiding non-elective admissions	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in non-elective (general + acute only)		Aggregated benefit of schemes for Reduction in non-elective (general + acute)	NHS Commissioner	344	2,150	739,600	Of the schemes due to start in FY14/15 it is estimated these schemes will collectively reduce non-elective admissions by 344 over the year. Please note due to gaps in data it has not been possible to quantify the impact of all of the listed schemes on non-elective admissions, so this figure may be considered a conservative estimate.	
Reduction in delayed transfers of care		15 a: Expand community Intermediate Care beds	NHS Commissioner			-	Assuming under the new pathway patients diverted from A&E direct to the CICU sub-acute ward have an average length of stay on this ward of 4 days, 7 of the 12 additional beds will also be available to support patients discharges from hospital wards (which is recognised as a pressure point for DToC). These extra 7 beds should help reduce DToC by 2,500, a benefit that we start to be realised in Oct-2014.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		15 d: Expand community Intermediate Care beds	NHS Commissioner			-	In Leeds around 50 bed days are lost in hospital each month due to DToC associated with housing issues. Whilst not all of these cases will involve homeless people, there is an expectation that by providing step-down beds through the HALP scheme, DToC for the homeless cohort will be significantly reduced, with an estimated saving of 17 bed days per month (a third of all housing-related DToC). This will impact from Jan-2015 onwards.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		12: Eldercare Facilitator	NHS Commissioner			-	Some trickled down on DToC may be expected as fewer admissions translate into fewer patients requiring assessment and/or care packaged on discharge. In addition by patients having care plans in place, barriers to discharge may be reduced. It is anticipated that the benefits of this service start impacting in Jan-2015.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		16 c: Enhancing Integrated Neighbourhood Teams	NHS Commissioner			-	The scheme proposes creating new discharge facilitation roles that will work with elderly patients to ensure timely discharge. Quantifying the impact of up-scaling the existing service by 3 WTEs is difficult as the opportunities for realising improvements relates to existing practices on the wards with which the staff will work.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		16 f: Enhancing Integrated Neighbourhood Teams	NHS Commissioner			-	Of the 3,380 Leeds patients who die in hospital each year, 60% have lengths of stay of 7 days or less, with 15% staying in hospital for 21 days or more. We do not have ready access to DToC figures for patients who die in hospital whilst awaiting an EoL care package at home, but from the figures above, the opportunities to avoid DToC are likely to be relatively limited.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
		15 b: Expand community Intermediate Care beds	NHS Commissioner			-	Efficiencies in the use of the CIC bed estate may also be expected to facilitate more timely discharge from hospital. This impact is difficult to quantify.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities
Reduction in delayed transfers of care		Aggregated benefit of schemes for delayed transfers of care	NHS Commissioner	1,344	220	295,680	Of the schemes due to start in FY14/15 it is estimated these schemes will collectively reduce delayed transfers of care by 1,344 over the year. Please note due to gaps in data it has not been possible to quantify the impact of all of the listed schemes on DToC so this figure may be considered a conservative estimate.	

Reduction in permanent residential admissions		12: Eldercare Facilitator	Local Authority	5	17,250	86,250	The increased access to dementia treatments and community support for dementia sufferers and their cares may be expected to support patients to remain living at home, delaying admission to long-term care. This impact is difficult to quantify and a conservative estimate of five delayed admisisons per year.	
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Total						**1,121,530**		

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		11: Enhancing primary care	NHS Commissioner	1,000	2,150	2,150,000	In Leeds 16,000 patients will be proactively managed under the GP DES each year. 49% of this cohort are likely to have one of more emergency admission to hospital during the year. Assuming the collective impact of the care planning approach mitigates risk of admission by 10% per patient, this equated to1,000 avoided admissions per year - a figure that ignores opportunities for reducing repeat admissions.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in non-elective (general + acute only)		15 a & b Expand community Intermediate Care beds	NHS Commissioner	420	2,150	903,000	Due to lack of available beds, it is estimated that 420 patients who could have been diverted from A&E into a CIC bed end up being admitted to hospital non-electively each year. By adding capacity to the system and re-designing the pathway this initiative is anticipated to avoid these admissions	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in non-elective (general + acute only)		16 f: Enhancing Integrated Neighbourhood Teams	NHS Commissioner	337	2,150	724,550	Increasing nursing capacity in the community is expected to allow between 300 and 500 more patients each year to choose to die at home rather than in hospital. Using NICE System Impact Modelling End of Life Tool, this additional support is expected to avoid 337 non-elective admissions. This figure is consistent with local intelligence for the opportunity saving associated with avoided non-elective admissions.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in non-elective (general + acute only)		12: Eldercare Facilitator	NHS Commissioner	200	2,150	430,000	Target to increase the number of dementia patients (at any point in time) who are known to primary care by 1,400 (by the end of FY15/16), of which 500 will likely fall within the 2% @ risk cohort. Accounting for churn in the populations (dementia patients have relatively short life expectancies), by identifying new dementia patients and putting care plans in place it has been estimated that 200 admissions to hospital will be avoided.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in non-elective (general + acute only)		1: Reablement services	NHS Commissioner	75	2,150	161,250	Scheme to be extended to see 840 people per year (which equates to 750 more packages of reablement each year), reducing risk of re-admission from 20% to 10% is anticipated to reduce non-elective admissions by 75 per year.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project
Reduction in non-elective (general + acute only)		2: Community beds	NHS Commissioner	73	2,150	156,950	Improved use of Community Intermediate Care (CIC) beds allows more patients to be transferred direct to a CIC bed, avoiding A&E attendances/hospital admission. Planned work to deliver internal efficiencies are expected to free up five beds to manage new community referrals, allowing 73 non-elective admissions per year to be avoided. This is predicated on increased community-referrals (where the patient would otherwise have been admitted to hospital).	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in non-elective (general + acute only)		15 d: Expand community Intermediate Care beds	NHS Commissioner	41	2,150	88,150	By case managing homeless patients on discharge from hospital there is an expectation that re-admissions to hospital for this cohort will be reduced. Assuming a 20% reduction in re-admissions, this equates to 41 avoided admissions per year.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in non-elective (general + acute only)		13: Medication prompting - Dementia	NHS Commissioner	160	2,150	344,000	Intelligence suggests 90% of dementia patients have one or more co-morbidities that require regular medication. Where an individual doesn't have regular care in place there is a risk of unplanned hospitalisation due to lack of compliance with medications.We estimate this will reduce admissions by the required level to at least meet the investment.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in delayed transfers of care		15 a: Expand community Intermediate Care beds	NHS Commissioner	2,500	220	550,000	Assuming under the new pathway patients diverted from A&E direct to the CICU sub-acute ward have an average length of stay on this ward of 4 days, 7 of the 12 additional beds will also be available to support patients discharges from hospital wards (which is recognised as a pressure point for DToC). These extra 7 beds should help reduce DToC by 2,500.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in delayed transfers of care		2: Community beds	NHS Commissioner	1,825	220	401,500	Stream-lining bed provision to more generic beds that can accept patients with a wider range of needs is expected to increase through-put, allowing more patients to access the service (estimated to be 5 fewer patients awaiting a CIC bed which equates to 1,825 fewer bed days lost due to DToC)	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in delayed transfers of care		11: Enhancing primary care	NHS Commissioner	640	220	140,800	Assuming the vast majority of patients being managed under the scheme are 65 and over, the reductions in admissions may be expected to reduce the total number of elderly patients being admitted to hospital by between 1.3 and 3.5% (based on the success of the scheme). Assuming a one-to-one relationship between admissions and DToC, this translates into DToC of between 240 and 640 lost bed days per year.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement

Reduction in delayed transfers of care		16 d: Enhancing Integrated Neighbourhood Teams	NHS Commissioner	300	220	66,000	Extending access to home care packages into the evening and over weekends is anticipated to facilitate earlier discharge of patients, helping reduce DToC. Currently DToC due to delays associated with accessing home care packages accounts for around 125 lost bed days per month. Whilst this additional capacity is unlikely to eliminate these delays, we expect the extra capacity to reduce delays by 20% for this cohort.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in delayed transfers of care		15 d: Expand community Intermediate Care beds	NHS Commissioner	204	220	44,880	In Leeds around 50 bed days are lost in hospital each month due to DToC associated with housing issues. Whilst not all of these cases will involve homeless people, there is an expectation that by providing step-down beds through the HALP scheme, DToC for the homeless cohort will be significantly reduced, with an estimated saving of 17 bed days per month (a third of all housing-related DToC)	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in delayed transfers of care		4: Leeds Equipment Service	NHS Commissioner	25	220	5,500	On average around 500 bed days are lost per year due to delays associated with community equipment. It is estimasted 25 of these may be avoided through the adoption of smarter technologies, but this is difficult to quantify	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in delayed transfers of care		16 c: Enhancing Integrated Neighbourhood Teams	NHS Commissioner	6,710	200	1,342,000	The scheme proposes creating new discharge facilitation roles that will work with elderly patients to ensure timely discharge. The existing service will be scaled up by 3 WTE to work with the existing teams to reduce excess bed days on general medicine by 50%.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in permanent residential admissions		1: Reablement services	Local Authority	75	17,250	1,293,750	People who otherwise would have been admitted to a care home are supported to stay at home (which is estimated to reduce admissions by 75 per year)	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in permanent residential admissions		2: Community beds	Local Authority	10	17,250	172,500	Small impact on admissions may be expected as rehabilitation services are more widely available,expectation is reduction in 10 admissions.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Reduction in permanent residential admissions		4: Leeds Equipment Service	Local Authority	6	17,250	103,500	Current plans propose extending existing service offer to include new technologies that enable more complex patients to be cared for at home,reducing admissions by 6.	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
Other	Reduction in LOS	15 d: Expand community Intermediate Care beds	NHS Provider	496	200	99,200	1652 bed days 30% reduction	The performance of each scheme is managed within the existing programme structures of Leeds's Health & Social Care Transformation Board, which ultimately reports to the cities Health & Welling Board. Routine project reporting in build into each scheme to foster continuous improvement
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Total						**9,177,530**		

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Leeds

Red triangles indicate comments

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,296**	**2,134**	**2,156**	**2,157**	**2,234**	**2,055**	**2,055**	**2,032**	**2,148**
	Numerator	17,680	16,431	16,605	16,611	17,326	15,938	15,941	15,765	16,780
	Denominator	770,068	770,068	770,068	770,068	775,666	775,666	775,666	775,666	781,245

Rationale for red/amber ratings

P4P annual change in admissions -2357
P4P annual change in admissions (%) -3.5%
P4P annual saving £5,067,550

Please enter the average cost of a non-elective admission[1]: **£2,150**

Rationale for change from £1,490: This is the average cost (including MFF) of an emergency admiss

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Leeds	% Leeds resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Bradford City CCG	3,279	3,023	3,121	2,963	0.5%	0.0%	18	16	17	16
NHS Bradford Districts CCG	9,433	9,421	9,084	9,243	0.8%	0.3%	72	72	69	71
NHS Leeds North CCG	4,104	3,811	3,853	3,853	96.4%	24.1%	3,957	3,674	3,714	3,714
NHS Leeds South and East CCG	6,429	6,016	6,082	6,082	98.5%	31.9%	6,332	5,925	5,991	5,991
NHS Leeds West CCG	7,233	6,657	6,731	6,731	97.9%	42.8%	7,084	6,520	6,592	6,592
NHS North Kirklees CCG	5,281	5,242	5,167	5,448	0.3%	0.0%	15	15	15	16
NHS Vale of York CCG	8,176	8,228	8,030	7,856	0.6%	0.2%	46	47	46	45
NHS Wakefield CCG	10,565	10,946	10,908	11,330	1.5%	0.6%	156	162	162	168
Total						**100%**	**17,680**	**16,431**	**16,605**	**16,611**

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

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Leeds

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**572.6**	**547.7**	**530.8**
	Numerator	650	645	635
	Denominator	113,350	117,764	119,621
		Annual change in admissions	*-5*	*-10*
		Annual change in admissions %	*-0.8%*	*-1.6%*

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**90.0**	**90.0**	**90.0**
	Numerator	80	90	270
	Denominator	90	100	300
		Annual change in proportion	*0.0*	*0.0*
		Annual change in proportion %	*0.0%*	*0.0%*

Rationale for red rating

The Leeds reablement service already performs well. We are looking to maintain that performance while increasing the throughput of patients through the

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**679.4**	**808.7**	**649.7**	**905.4**	**991.4**	**1,145.0**	**981.5**	**893.7**	**812.4**	**731.2**	**649.9**	**565.1**
	Numerator	4,096	4,876	3,917	5,535	6,061	7,000	6,000	5,500	5,000	4,500	4,000	3,500
	Denominator	602,908	602,908	602,908	611,329	611,329	611,329	611,329	615,434	615,434	615,434	615,434	619,310
						Annual change in admissions	*6137*					*Annual change in admissions*	*-7561*
						Annual change in admissions %	*33.3%*					*Annual change in admissions %*	*-30.8%*

Patient / Service User Experience Metric

Metric		Baseline	Planned 14/15 (if available)	Planned 15/16
Leeds is working to develop a bespoke patient experience survey that can be run in primary and community care settings to cover patients' experiences of integregrated health and social care services.	*Metric Value*			
	Numerator			
	Denominator			
Improvement indicated by:	<Please select>			

Local Metric

Metric		Baseline Census - End March 2014	Planned 14/15 (if available)	Planned 15/16
Dementia Diagnosis Rate	*Metric Value*	0.5	0.7	0.7
	Numerator	4,996	5,982	6,397
	Denominator	8,500	8,927	9,138
Improvement indicated by:	Increase			

References/notes

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014)

1. Based on "Personal Social Services: Expenditure and Unit Costs, England2012-13" (HSCIC) http://www.hscic.gov.uk/catalogue/PUB13085/pss-exp-eng-12-13-fin-rpt.pdf
2. There is no robust national source for the average annual saving due to being at home 91 days after discharge from hospital in to reablement / rehabilitation services. Therefore HWBs should provide the estimate that underpins their planned financial savings, which it is assumed will include the impact of reduction admissions to hospital and to residential care
3. Based on 12-13 Reference Costs: average cost of an excess bed day. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf

service

Rationale for red ratings

In the short-term Leeds expects to see a deterioration in performance as recruitment/training lags associated with increasing community nursing capacity prevents the benefits from smarter discharge management within the acute sector from being fully realised.

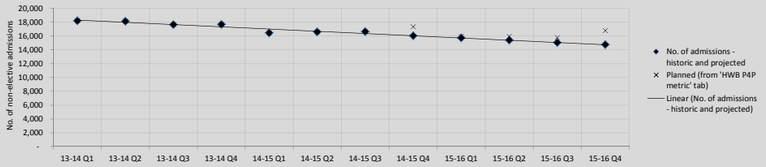
Leeds

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	18,205	18,132	17,635	17,680	16,431	16,605	16,611	16,037	15,714	15,391	15,068	14,745

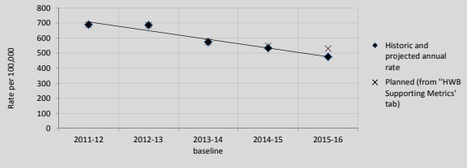


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,082.5*	*2,025.9*	*1,984.2*	*1,942.6*	*1,887.4*
	Numerator	*16,037*	*15,714*	*15,391*	*15,068*	*14,745*
	Denominator	*770,068*	*775,666*	*775,666*	*775,666*	*781,245*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

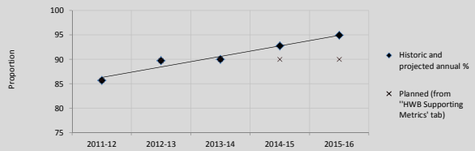
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	688	685	573	*533*	*476*
	Numerator	760	775	650	*628*	*569*
	Denominator	110,210	113,350	113,350	*117,764*	*119,621*



This is based on a simple projection of the metric proportion.

Reablement

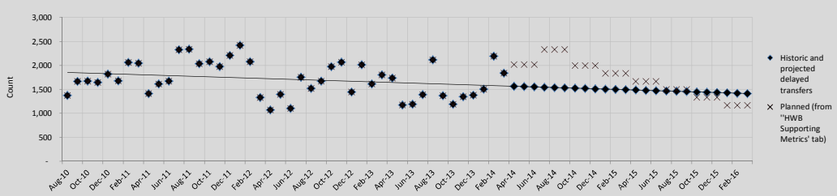
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	85.7	89.7	90	*92.8*	*94.9*
	Numerator	55	60	80	*83*	*85*
	Denominator	65	70	90	*90*	*90*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic																													Baseline											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	1,375	1,666	1,671	1,647	1,817	1,679	2,065	2,046	1,413	1,613	1,674	2,330	2,340	2,037	2,080	1,977	2,207	2,422	2,076	1,329	1,072	1,394	1,104	1,751	1,522	1,673	1,978	2,067	1,447	2,013	1,614	1,803	1,736	1,171	1,189	1,391	2,116	1,369	1,190	1,345	1,382	1,502	2,193



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*764.4*	*754.7*	*745.1*	*730.5*	*720.9*	*711.3*	*701.7*	*687.8*
	Numerator	*4,673*	*4,614*	*4,555*	*4,496*	*4,437*	*4,378*	*4,318*	*4,259*
	Denominator	*611,329*	*611,329*	*611,329*	*615,434*	*615,434*	*615,434*	*615,434*	*619,310*

* The projected rates are based on annual population projections and therefore will not change linearly

	Linear projection* (set so cannot fall below zero)																							
Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
1.840	1.564	1.558	1.551	1.545	1.538	1.531	1.525	1.518	1.512	1.505	1.499	1.492	1.485	1.479	1.472	1.466	1.459	1.453	1.446	1.439	1.433	1.426	1.420	1.413

HWB Financial Plan

Date	Sheet	Cells	Description
28/07/14	Payment for Performance	B23	formula modified to *=IF(B21-B19<0,0,B21-B19)*
28/07/14	1. HWB Funding Sources	C27	formula modified to *=SUM(C20:C26)*
28/07/14	HWB ID	J2	Changed to Version 2
28/07/14	a	Various	Data mapped correctly for Bournemouth & Poole
29/07/14	a	AP1:AP348	Allocation updated for changes
28/07/14	All sheets	Columns	Allowed to modify column width if required
30/07/14	8. Non elective admissions - CCG		Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
30/07/14	6. HWB supporting metrics	D18	Updated conditional formatting to not show green if baseline is 0
30/07/14	6. HWB supporting metrics	D19	Comment added
30/07/14	7. Metric trends	K11:O11, G43:H43,G66:H66	Updated forecast formulas
30/07/14	Data	Various	Changed a couple of 'dashes' to zeros
30/07/14	5. HWB P4P metric	H14	Removed rounding
31/07/14	1. HWB Funding Sources	A48:C54	Unprotect cells and allow entry
01/08/14	5. HWB P4P metric	G10:K10	Updated conditional formatting
01/08/14	5. HWB P4P metric	H13	formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
01/08/14	5. HWB P4P metric	H13	Apply conditional formatting
01/08/14	5. HWB P4P metric	H14	formula modified to *=if(H13="","",-H12*J14)*
01/08/14	4. HWB Benefits Plan	J69:J118	Remove formula
01/08/14	4. HWB Benefits Plan	B11:B60, B69:B118	Texted modified
Version 2			
13/08/14	4. HWB Benefits Plan	I61, I119, J61, J119	Delete formula
13/08/14	4. HWB Benefits Plan	rows 119:168	Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
13/08/14	4. HWB Benefits Plan	rows 59:108	Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
13/08/14	3. HWB Expenditure Plan	rows 59:108	Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
13/08/14	a	M8	Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*'
13/08/14	HWB ID	J2	Changed to Version 3
13/08/14	6. HWB supporting metrics	C11, I32, M32	Change text to *'Annual change in admissions'*
13/08/14	6. HWB supporting metrics	C12, I33, M33	Change text to *'Annual change in admissions %'*
13/08/14	6. HWB supporting metrics	C21	Change text to *'Annual change in proportion'*
13/08/14	6. HWB supporting metrics	C22	Change text to *'Annual change in proportion %'*
13/08/14	6. HWB supporting metrics	D21	Change formula to *=if(D19=0,0,D18-C18)*
13/08/14	6. HWB supporting metrics	D21	Change format to 1.dec. place
13/08/14	6. HWB supporting metrics	E21	Change formula to *=if(E19=0,0,E18-D18)*
13/08/14	6. HWB supporting metrics	E21	Change format to 1.dec. place
13/08/14	6. HWB supporting metrics	D22	Change formula to *=if(D19=0,0,D18/C18-1)*
13/08/14	6. HWB supporting metrics	E22	Change formula to *=if(E19=0,0,E18/D18-1)*
13/08/14	5. HWB P4P metric	J14	Cell can now be modified - £1,490 in as a placeholder
13/08/14	5. HWB P4P metric	N9:AL9	Test box for an explanation of why different to £1,490 if it is.
13/08/14	4. HWB Benefits Plan	H11:H110, H119:H218	Change formula to eg. *=H11*G11*
13/08/14	2. Summary	G44:M44	Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab

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SCHEME NAME :- REABLEMENT	
SCHEME NO	**01**
RESPONSIBLE GROUP	**Better Lives Through Integrated Services**
ACCOUNTABLE LEAD OFFICER	**Dennis Holmes – Michele Tynan / Paul Morrin**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	**V0.3, 18/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Reablement of service users to allow them greater independence to remain in a home environment for longer.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

We acknowledge that increases on demand on the Re-ablement service mean that the Re-ablement service needs to increase capacity if it is to meet this demand. We intend to expand reablement through the transfer of staff from long term community support aimed at increasing productivity. The impact of this additional capacity on waiting times will be tracked through the introduction of a data gathering process which tracks the whole process from service request to assessment visit to service start and end dates (Caretrak). This data can be reported on an area by area basis to compare and measure consistency across Leeds and will also be able to isolate hospital discharge and community referrals. This can be used to develop a baseline for future activity and the baseline can be used to identify target response times to support the integration of the Re-ablement service with Intermediate Care.

The CareTrak system will be used to look at the antecedents prior to entry into the Re-ablement service and the impact post discharge from the service in terms of unscheduled hospital admissions and readmissions. As part of the development of the service specification for the integrated service (Known as L.I.L.T.), specific KPIs will be used relating to impact on hospital activity.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This will be through the Better Lives through Integration Board, jointly chaired by Leeds ASC and Leeds Community Healthcare, who will also refine the above metrics to ensure they are

fit-for-purpose for both organisations, and to add any additional required metrics as work develops.

The Reablement/ICT Integration Project Board will provide quarterly reports on the above high level metrics to the the Better Lives Board, which will in turn report through the Transformation Board and link to the Health and well Being Board.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

At the time of writing, the Leeds reablement service runs at a comparatively low volume of throughput. The service however is efficiently run and well managed – the service has consistently achieved the target 90% of patients going through the service not needing hospital treatment within 91 days.

Our plans for the service in Leeds is to maintain this strong performance, but to increase the throughput of the service.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 4,512 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The evidence on reducing costs on more expensive services by reducing demand through reablement are well documented

We expect a reduction in LOS and Admissions of 5%

The principles that the Clinical Commissioning Groups and Leeds ASC expect to be delivered through applying the BCF to reablement are:

- Ability to demonstrate that short term investment has the potential to lead to long term change for the future, supported by agreed performance metrics to show what has been achieved.
- Ability to demonstrate [inc. metrics] via service delivery:

    a) True integrated working
    b) Patient/user care benefits,
    c) Improved whole system working,
    d) Reduced duplication
    e) Fewer hand-offs

- Ability to demonstrate [inc. metrics] across the whole system:

    f) Improved productivity,
    g) Improved value for money
    h) More efficient services

These principles were initially outlined in the 'Smoothing the Pathway' and the 'Local Authority Proposal Adults and Children's Services' papers agreed between NHS Leeds and Adult Social Care which outline the specific schemes that were being supported by the transfer of monies covered by the previous s256 agreements.

As per metrics spreadsheet:

1) Average elderly acute admission cost is £2,500. 'Individuals who access reablement services will be less likely to be re-admitted to hospital (assuming 840 new clients access the service, which if untreated who have had a 20% risk of readmission and on treatment have a 10% readmission rate)
2) The expectation is that there will be a threefold increase in throughput of the reablement service by April 2015. The city has a trajectory to reduce the number of permanent residential admissions by 48, this year. Our estimate is that this scheme will contribute 10 to this service.

Due to lack of available beds, it is estimated that 420 patients who could have been diverted from A&E into a CIC bed end up being admitted to hospital non-electively each year. By adding capacity to the system and re-designing the pathway this initiative is anticipated to avoid these admissions.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of*

the proposal to your overall objectives?
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME
- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Service development work undertaken by NHS Leeds and Leeds ASC for long term change towards service integration must be supported by agreed performance metrics, reported on a regular basis - to show what has been achieved, and what work remains to be done.

The following metrics will be used to monitor the short term objectives

- Reduced hospital admissions
- Long term care placements
- Long term homecare packages
- Reduction in Length of stay in ICTs
- Increased throughput in ICTs
- All patients picked up by Local Authority within 48 hours of approval by

gatekeeping panel
    - Reduced number of delayed discharges
    - Reduction in number of homecare hours being picked up by intermediate care teams

The reablement service also currently gathers the following metrics which will be considered going forward for both the Reablement Service and ICT:

Service activity

- Number of Assessments completed
- Volumes [in/outflow]
- Proportion of customers diverted to re-ablement from long term care
- Percentage of referrals, respectively, from community and hospital
- Number of packages of delivery of service completed
- Service duration [average length of service programme]
- Average length of intervention and number of hours delivered per package per week
- Reduction in delivered hours

Quantitative Outcomes [post reablement]

- No service
- Reduced service
- No change
- Increased package
- Non-completers
- De-selected

Qualitative outcomes [post reablement]

- ASCOT direction of travel questionnaire responses
- Outcomes of intervention, including impact on individual and impact on other service usage

Consideration will also be given to establishing longitudinal records, in order that the long term impact of services can be monitored. The recent DH consultation document proposed the following measure: 'proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into reablement or rehabilitation services

It is intended that the team will be integrated in 2015/16.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

This is an established service and any risks are currently being managed through the Better Lives Through Integrated Board and the Service Delivery Group for Reablement.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*

- *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- Community Beds	
SCHEME NO	**02**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan / Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

This scheme is focussed on enhancing our community services to prevent acute admission and facilitate discharge. This funding supports a network of intermediate care beds and services.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

£5.3M for the provision of 121 units of nursing and residential short-stay community beds. The beds are currently all operationalised and work is being driven through the Leeds Transformation Programme (community Beds Strategy) to improve the performance of the beds and the outcomes for service users/patients. The beds act to facilitate prompt discharge and reduce length of hospital stay. For some patients they can also be used as a "step up" service to prevent acute admission. This is part of the Leeds Neighbourhood Integrated Health and Social delivery model.
Improved throughput through the beds through care management by the Leeds integrated Neighbourhood Teams model will meet growing demographic demand and reduce delayed discharges. An increased focus on timely admission avoidance both from the community and from A&E/ short stay assessment areas will see more care provided closer to home and fewer inappropriate acute admissions.
Leeds progress to also be monitored through participation in the 2014 national Audit of Intermediate Care.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The development of a Leeds Community Beds Strategy as a component of the wider Leeds Transformation Programme ensures that a joined up approach to development has taken

place and that the development of community beds in viewed within the context of :-

- Support self-management of care
- The local integrated health and social care model of care (including Primary Care)
- Vertical integration (including admission and discharge initiatives) with the acute hospital trust

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- To support the selection and design of this scheme
- To drive assumption about impact and outcomes.
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The existing community bed estate will be used more efficiently and will be changes so that it accepts patients with a wider range of needs, increasing the throughput of patients in the service.

INVESTMENT REQUIRED

- Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

£5,300,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- Identify the key stakeholders and the impact of the proposal on them?
- Reduce activity (whole system/specific)
- Reduce cost (whole system/specific)
- Improve patient experience.
- Impact BCF metrics (BCF national conditions / performance targets)
- Other locally important measures or metrics.
- What Research and evidence have you consulted to generate a set of assumptions about future outcomes?

The impact:-
Maintaining this level coupled with remodelling/pathway improvements could impact as follows:-
Currently approx. 35% of CIC placements are admission avoidance (65% hospital discharge)= 759 placements. With an aim of stretching performance to achieve 50% admission avoidance in 5 years (by April 2019) as opposed to the current 35%, this would equate to 1165 admission avoidances per annum, an increase of 406.

Typical acute HRG for CIC patient is £2,500 (not including A&E costs, transport etc.).
406 x £2,500= £1M potential saving per annum

An incremental rise is expected towards this potential level of recurrent savings:-
April 2016 £0.25M
April 2017 £0.4M
April 2019 £1M

'Small impact on admissions may be expected as rehabilitation services are more widely available,expectation is reduction in 10 admissions.

'Stream-lining bed provision to more generic beds that can accept patients with a wider range of needs is expected to increase through-put, allowing more patients to access the service (estimated to be 5 fewer patients awaiting a CIC bed which equates to 1,825 fewer bed days lost due to DToC)

'Improved use of Community Intermediate Care (CIC) beds allows more patients to be transferred direct to a CIC bed, avoiding A&E attendances/hospital admission. Planned work to deliver internal efficiencies are expected to free up five beds to manage new community referrals, allowing 73 non-elective admissions per year to be avoided. This is predicated on increased community-referrals (where the patient would otherwise have been admitted to hospital).

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- What is your approach to measure the impact of this proposal?
- What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?
- Can you set up a counterfactual or control?
- Will data be generated automatically or does it require a new survey / data collection approach?

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an “Outcomes Based Accountability” (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- E.g. expertise, staff, demographics, history of partnership working.
- Do these also exist within the local area?
- If not – have actions been put in place to resolve this?
- OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?
- An outline of a stepped approach to implementation which draws on
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The key success factors are:-

1 Reduction in length of stay (LoS) of all individuals accessing the service
2 Number of individuals discharged from the service
3 Bed Occupancy Levels
4 Number of days closed to admissions.
5 Number of Incidences reported to infection control.
6 Improvement in Therapy Outcomes Measures (TOMs) scores and EQ5D Health Status scores from admission to discharge
7 Reduction in the number of older people transferring directly to long term care
8 % service users discharged to hospital from the beds (admissions and re-admissions)
% of these originally admitted from the community
% of these originally admitted from hospital
9 Number of acute readmissions to hospital within 72 hours of admission to the service (for service users that had originally been admitted from hospital)
10 Number of days delayed discharge from service due to inability to discharge a patient/service user
11 Customer satisfaction during stay in unit prior to discharge
12 % receiving Tier 1 Falls assessment
% with 3+ score on FRAT receiving Tier 2 assessment
13 Circumstances/ services received of service users prior to unit and 3 months and 6 months post discharge from the service
14 No. of people in long term care/ receiving an intensive level of care 3 months and 6 months post discharge from the service
15 No. short stay hospital attendances 3 months and 6 months post discharge from the service
16 Increased proportion of users from the community in relation to those discharged from hospital

In terms of timeframes, the community beds are already operational with ongoing monitoring of the above.

KEY RISKS

- To the success of the proposal

- To other parts of the system as a whole (i.e. potentially unintended consequences)
Risks will be managed through the local community bed group.
PROPOSAL IMPLEMENTATION PLAN - Start date - End date - List of key deliverables and the dates associated. - Outline roles and responsibilities for delivery and implementation of the proposal.
Small impact during 2014/15 with continued implementation during 2015/16.

SCHEME NAME :- Supporting Carers	
SCHEME NO	**03**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Matt Ward**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Support to Carers
This includes Carers supporting people across a range of client groups: Older People (Inc. Dementia) Learning Disability, Mental Health, Children with Complex needs, Disabled people and Child Carers

Support to Carers allow people to continue in their caring role, allowing people to stay at home, remain independent and take part in communities

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The funding will support a range of initiatives, notably:
Respite Care (both bed based, Community based and within own homes)
Flexible support Inc. Direct Payment models
Information and advice
Access to training
Peer Support
Health and well Being support for Carers
Support to stay in employment
Support in Hospitals
Taking referrals from and support to Primary and Community Health Services
Support to neighbourhood teams and services
Support to recently bereaved carers
And additional activity (Inc. Assessment required under the Care Act

The impact on Carers and evidence on supporting the Health Economy is substantial (see National and Leeds Carers Strategy)
Effective Carers services will reduce inappropriate entry into hospital (5%)
Reduced length of stay through effective Carer engagement in hospitals and across the pathway (2%)
More Effective Discharge and reduced re-admissions (5%)

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This is steered through the multi-agency Carers Strategy Implementation Group which in turn informs and is informed by city wide strategic groups including those associated with client groups (Learning Disability, Mental health, Dementia etc.) and wider strategic partnerships (Urgent Care Board, Transformation Board, H and WB Board)

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The funding for this scheme is recurrent monies and we do not expect this scheme to have an impact over and above the current baseline performance.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,059,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about*

future outcomes?

2016 Increased Carer Services and Carer Satisfaction - this will support the reaching of targets identified in other business cases
2017 As above
2019 As above
2021 As above

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and

ii) engagement with partners about the deliverability of the proposal
Engagement with Carers at every level – both in regard to individual caring role and at a service and strategic level Carer Led delivery of services Understanding of the impact of Carers on the whole system Understanding of impact of carer health Recognition of Carers as equal partners in the planning and delivery of support for the cared for person Establishment of one carer point of contact number achieved in 2014 Expanded Respite provision (across different models) 2015 Implementation of Care Act in regard to Carers 2015
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
This will be managed through the local carers strategy group
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015/16

SCHEME NAME :- Equipment Service	
SCHEME NO	**04**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Delivery of Community Equipment (Inc. Telecare) through an integrated Health and Social Care Team to support people to stay/gain independence
Linked to Scheme 16 where we will invest further to expand cover to 7 days per week.

Service Objectives

Service users receive their equipment in a timely manner, and are given guidance and information on safe use of equipment -

- Assessors are informed when specific equipment, which requires fitting and training by the Assessor, is delivered.
- Assessors receive information about the service.
- Service user feedback and complaints are used to inform onward development and improvements to the service.
- Incidents and near misses are reported in accordance with Local Authority, NHS and national reporting requirements.
- The services are compliant with MHRA Medical Devise guidance, the Local Authority and NHS Infection control and Prevention policies to ensure that the risk of contamination and cross infection is minimized
- The Services used different methods of decontamination to address varying levels of contamination, depending on the equipment, risk assessment classification and it's use, in accordance with infection control guidance and manufacturing guidelines

OVERVIEW OF THE SCHEME --- *point 1 from the old format*
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

To support significant investment in community equipment (Health and Social Care) to support safe hospital discharge and people to remain at home safely and independently.

Service Aims: The primary aim of the service is to obtain, deliver and install the right community equipment within agreed timescales to enable people to live independent inclusive lives. Once the customer has no further use for the equipment it will be returned/collected, cleaned and, where possible, fully serviced and then re-used.

Specific aims include:

- To provide community equipment for people to use in a variety of community settings
- To procure, purchase and lease equipment.
- To deliver and install equipment at the appropriate request of a range of health and social care assessors.
- To collect, clean, refurbish and maintain equipment and maintain equipment that is returned to the store.
- To provide advice, education and support to health and social care professionals regarding the ordering, safe use and maintenance of equipment.
- To provide information to service users, carers and public on Assistive Technologies including signposting to other providers.

Leeds Community Equipment (LCES) and Tele Care Services will provide community equipment to support and enable people to live safe, independent and inclusive lives. The service is important to the prevention agenda and provides a vital gateway to independence, dignity and well-being for many people living in the community. The provision of equipment enables safe rapid discharge from hospital and hospital admission avoidance

The service will also provide, through delivery of community equipment

- Support individuals with chronic health conditions and long term care needs to maximise independence and choice.
- Support the delivery of quality care at the end of life.
- Enable social inclusion.

The service will provide community equipment to four main customer groups:

- Adults with general Health and Social Care needs (including all impairments)
- Children with general Health and Social Care needs.
- Children eligible for NHS Continuing Healthcare Funding.
- Adults eligible for NHS Continuing Healthcare Funding (CHC)

Service Standards

- To deliver and install standard community equipment within 7 days of request by Health and Social Care Professionals. To deliver and install Tele care equipment to TSA standards.
- To deliver and install standard community equipment within 24 hours of request by Continuing Healthcare.
- To deliver and install standard community equipment within 48 hours of request by Intermediate Care Teams, Hospital Discharge Teams, Re-ablement Teams and Children's Services (end of life care for children).
- To deliver and install non- standard community equipment within 2 weeks of item received in store.
- To maximise value for money and efficiency through re-utilisation of community equipment.
- Ensure that the equipment store's management systems meet the relevant health and safety standards.
- Ensure performance management and quality assurance systems are in place.
- Ensure that the equipment purchased and supplied is of a high standard and meets specifications as agreed.
- To respond to faults of Telecare Equipment within 24 hours and low battery alerts in a timely manner.
- To maintain equipment in accordance with legislation and manufacturers recommendations including portable appliance testing (PAT) on equipment returned to LCES and related record keeping on certification
- Ensure staff working within the Leeds Community Equipment and Tele Care Service, are fully competent and trained in relation to all equipment, to deliver a high standard of service.
- Ensure disabled people, including service users accessing the Leeds Community Equipment Service are consulted and engaged in the delivery and development of LCES.
- Provide comprehensive, up-to-date, accessible information for potential and actual community equipment customers.
- Ensure an effective system for reporting adverse incidents is in place.
- To work in partnership with the Leeds Disabled Living Centre.
- To be responsive to changing requirements for community equipment as identified by

statutory regulations.

- Work with other assistive technology services across health and social care and the third and independent sector.
- To engage with assessors, equipment manufacturers and suppliers.
- To provide opportunity for assessors to view equipment across the Service by appointment.
- To provide 24 hour telephone monitoring centre for Tele Care customers, ensuring a response is given to an alert is raised if the sensor activates or detects any problems.
- To provide accurate information about current stock in stores, including service and maintenance history, on request

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Through existing integrated Commissioning and delivery boards for equipment services Linked to service areas and wider Transformation Board and H and WB Board

THE EVIDENCE BASE--- *point 2, 3 from the old format*
Please reference the evidence base which you have drawn on,

- To support the selection and design of this scheme
- To drive assumption about impact and outcomes.
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Moving the service to a 7 day a week service, and broadening the range of technologies available, will support people to continue to live in their own homes and support quicker discharge and reduced delayed transfers of care.

INVESTMENT REQUIRED --- *point 5 from the old format*

- Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

£2,300,000

IMPACT OF THE SCHEME *--- point 4, 6, 7 & 10 from the old format*

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- Identify the key stakeholders and the impact of the proposal on them?
- Reduce activity (whole system/specific)
- Reduce cost (whole system/specific)
- Improve patient experience.
- Impact BCF metrics (BCF national conditions / performance targets)
- Other locally important measures or metrics.
- What Research and evidence have you consulted to generate a set of assumptions about future outcomes?

Service Outcomes

1. Disabled Adults, Older People and Children can stay at home in a safe environment.
2. Paid and unpaid caters are supported and safe.
3. Statutory organisations' risks are managed.
4. Assessors are skilled and working efficiently.
5. The service shall be responsive to the needs of Service users and assessors.

We intend from November 2014 to deliver this from a purpose built facility, linked in to associated services this will include developing high end technological solutions in including greater use of Telecare, and Information Management Technology and emerging technologies (inc. health and well-being apps and higher end equipment (e.g. glance technology)
The new build will in future establish and support innovation including a Retail Unit, 'Smart House and 'Innovation Lab' (This will be funded through external partner investment).

There is strong evidence from both local evaluations of the existing Community Equipment service and the national guidance that effective equipment services reduce demand on acute care, particularly in regard to effective and speedier discharge. This includes:

- Integrating Community Equipment Services, DH (2002)
- Transforming Community Equipment Services (TCES) June 2006
- The Department of Health guidance

- NICE guidance
- MHRA advice and alerts
- HSE legislation
- Putting People First (Transforming Adult Social Care)
- A Vision for Adult Social Care: Capable Communities and Active Citizens
- Vision for Leeds 2011 – 2030.
- The Time Of Our Lives: Ageing Well in Leeds
- CECOPS 2012 – Community Equipment Code of Practice
- TSA Code of Practice – Telecare Services Association

We would expect that to continue at 10% of discharges being able to me quicker by 5% - 20%

2016 5% reduction in LOS
2017 5% Reduction in LOS
2019 10% reduction in LOS
2021 10% reduction in LOS

On average around 500 bed days are lost per year due to delays associated with community equipment. It is estimated 25 of these may be avoided through the adoption of smarter technologies, but this is difficult to quantify

'Current plans propose extending existing service offer to include new technologies that enable more complex patients to be cared for at home, reducing admissions by 6.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- What is your approach to measure the impact of this proposal?
- What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?
- Can you set up a counterfactual or control?
- Will data be generated automatically or does it require a new survey / data collection approach?

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in

the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- E.g. expertise, staff, demographics, history of partnership working.
- Do these also exist within the local area?
- If not – have actions been put in place to resolve this?
- OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?
- An outline of a stepped approach to implementation which draws on
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- Integrated Services
- Pooled Budget
- Expansion into new technologies
- Information on options
- Opportunities to display and test equipment

The service will deliver on a range of services for Children and Adults:

Adult Equipment

- The service will ensure that equipment is purchased using appropriate and robust procurement arrangement.

- The service will stock/store both new and re-cycled equipment at the main store and limited equipment in identified peripheral stores around the city.

- Re-cycled equipment will be reviewed based on the length of time it remains in store

without being reissued and a decision made on retention or disposal.

Children's Equipment

- The service will stock/store both new and re-cycled equipment at the main store and limited equipment in identified peripheral stores around the city.

- Re-cycled equipment will be reviewed based on the length of time it remains in store without being reissued and a decision made on retention or disposal.

Adult Continuing Care

- The service will ensure that equipment is purchased using appropriate and robust procurement arrangements.

- The service will stock/store both new and re-cycled equipment either at the main store and limited equipment in identified peripheral stores around the city.

- Re-cycled equipment will be reviewed based on the length of time it remains in store without being reissued and a decision made on retention.

- Provision of a dedicated enhanced Planned Preventative Maintenance Fitting service for Adult continuing care (1 WTE post)

Telecare and Care-Ring

- The service will ensure that equipment is purchased using Local Authority procurement arrangements.
- The service will stock/store both new and re-cycled equipment at the main store in the city.

KEY RISKS --- *point 8 & 9 from the old format*

- To the success of the proposal
- To other parts of the system as a whole (i.e. potentially unintended consequences)

PROPOSAL IMPLEMENTATION PLAN

- Start date
- End date
- List of key deliverables and the dates associated.

- Outline roles and responsibilities for delivery and implementation of the proposal.
Maintaining current funding – 13/14 Formalising and expanding joint delivery arrangements between LCC and LCH – April 2014 Fully jointly funded service with Pooled Budget arrangement between LCC and CCG's April 2014 New build to operate integrated service open November 2014 Expansion into new technologies 2015-17 Smart House/Innovation lab – 2017/18

SCHEME NAME :- Third Sector Prevention	
SCHEME NO	**05**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Leeds has a vibrant third sector, supporting citizens and service users to stay well, maintain independence and lead an active, safe and engaged life within communities
This includes a strong focus on services for older people, people with mental health needs, learning disability and Long Term Conditions

Maintaining funding for these services will enable the continued support to individuals and the increasing integration of these services within health and social care pathways

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

This area covers a huge range of interventions across client groups and communities
Key areas include:
Neighbourhood Networks – particularly services to tackle loneliness and Isolation and Healthy and Active Life (Inc. Exercise, Malnutrition/Hydration) (as outlined in the Institute of Public Policy Research document – Generation Strain and numerous papers on Older People's well-being)
Community and User Led Mental Health Services (NSF for mental Health, Mental Health Framework)
Dementia Services – See Prime Ministers Challenge/National (and Leeds) Dementia strategy
Sensory and Physical Impairment services (National Vision Strategy, RNID Health impact of hearing Loss etc.)
Advocacy – (See The Care Act)
Leeds Directory – Information o services (Care Act etc.)
Social Prescribing (testing and developing new models)

All of these, and many more funded through LCC and CCG's and partner funders, create a community of support, allowing people to avoid unnecessary hospital avoidance (5-10% of relevant client group) reduced Length of stay (10% esp. in older people's and mental health facilities) and provide more effective discharge and reduced re-admissions (10%)

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Through the cities partnership boards and joint working/integrated initiatives

These are at both specific service area/client group level (Dementia Board, Mental Health Board) and at a macro level: Transformation Board, Health and Well Being Board

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This is a recurrent scheme and we do not expect that it will have a benefit over and above the current set of Leeds baseline performance against the BCF metrics.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 4,609, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*

- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

April 2016 Continued Hospital Avoidance as outlined above
2017 - this will support the reaching of targets identified in other business cases
2017 As above
2019 As above
2021 As above

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and

ii) engagement with partners about the deliverability of the proposal

Key are:
Co-production between commissioners, community organisations and communities
Sustainable funding
Outcomes focussed commissioning
Asset Based Community Development approach
Investment in expanding Community Capacity

All of these services are part of an ongoing commissioning cycle – Identify Needs, Plan service type, Implement and then review
The BCF will allow for this to be maintained, whilst enabling a shift towards a stronger focus on invest to save for the health economy

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Joint adult commissioning group

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

April 2015

SCHEME NAME :- Admission Avoidance within LTHT	
SCHEME NO	**06**
RESPONSIBLE GROUP	**Joint Adults Commissioning Group**
ACCOUNTABLE LEAD OFFICER	**Sandie Keene / Phil Corrigan**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

To reduce the impact of unplanned admissions within the acute trust through improving management of patient flow within A&E and enabling effective assessment prior to decision to admit.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

Flow managers within A&E, effective triage by Consultant geriatrician in A&E, provision of pre admission assessment units and effective early support discharge team - a multiagency team including community health practitioners within LTHT. (Linked to scheme 16 where the EDAT team is being funded to extend their working hours and cover 7days per week).

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This scheme is closely linked to both the Admission and Discharge Group, the Transformation Board and the H&WBB.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*

- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This funding is an existing allocation of money, and we do not expect it to contribute to the Leeds performance over and above the baseline position.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,800, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Further work is currently underway to fully assess the impact.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection*

approach?

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In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Further work is currently underway to fully assess this.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Reduced number of people who attend LTHT as an unplanned attender will be admitted.
Efficient assessment within A&E, transferred for assessment as required.
People will be fully supported to access the right care in a timely way out of hospital.
Improved access to expanded community services.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*

- *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- Community Matron	
SCHEME NO	**07**
RESPONSIBLE GROUP	TBC Brian Collier (Transformation Director) Mark Hindmarsh (interim project manager)
ACCOUNTABLE LEAD OFFICER	Andy Harris/Ian Cameron
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Currently community matron services in the city are funded by CCGs and are core part of the integrated neighbourhood teams. Transferring this service into the BCF will support further enhancement and integration of this service into the wider integrated health and social care model.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The community matron service is well-established in Leeds. Community matrons work as an integral part of the Integrated Health and Social Care teams to ensure each patient has a carefully coordinated personalised plan of care based on a holistic assessment of need using their advanced skills and referring on as appropriate. All Community Matrons manage an active caseload of ca. 50 adults with long term conditions. Patients are proactively identified using the risk stratification tool, local intelligence and other professionals through local MDT processes

Future developments and proposals for expanding the service are set out separately in scheme number 16. These developments aim to:

- Fully embed proactive case management processes
- Increase service capacity & efficiency
- Complement the primary care schemes in reducing admission, readmission and supporting safe and timely hospital discharge.

Service Model:

Community Matrons pro-actively manage patients with long term conditions within a model which includes;

- Utilisation of the risk stratification tool to identify a list of patients who are at high risk of admission in the next 12 months and would most benefit from a pro-active planned

approach to their care with integrated working between primary, community services and the local authority.
- Promoting self-care for patients through innovative interventions, information and education.
- Implementation of personalised care planning that put people at the centre of decisions about their care with a focus on goal setting, holistic needs and prevention.
- Care co-ordination and pro-active clinical case management of complex patients

Every GP practice has a named Community Matron(s) who will have a lead role in working with the GP practice to provide effective management interventions to reduce the risk of unplanned admission for patients with high/moderate risk. This is part of the Integrated Health and Social Care Team, working through the MDT approach with practice populations. Community Matrons are autonomous practitioners who utilise core competencies outlined by the NHS Modernisation Agency (DOH 2005) and as described by Skills for Health to plan and coordinate ways of meeting all health and social care needs of specific groups of people with long term conditions. This creates a person centred approach and support people to take responsibility for their own condition and encourage self-care to improve health outcomes and patient satisfaction.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The service is a key part of the Integrated Health and Social Care Team model. Planned further develops to the service (as outlined in scheme 16) are core components of the CCG and adult social care commissioning plans.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The population of Leeds is estimated at > 800,000. The emerging common issues for Leeds include; changes in population (80% of the population are under 60 years of age, 24% aged below 20 years of age, nearly 16% of the population are over the age of retirement –below both national and regional averages), diverse communities, city-wide variation in need (adults and older people, carers), health inequalities, mortality and deprivation. People aged 65 and over make up approximately 16% of the Leeds population but occupy almost two

thirds of general and acute beds. National policy aims to prevent avoidable and inappropriate hospital admissions particularly for older people and those with Long Term Conditions (LTCs).

People with LTCs are amongst the most intensive users of health services and with an ageing population the number of people with at least one LTC is rising. The incidence of people with more than one LTC is also rising, and leads the focus of commissioning services from disease-specific pathways to a holistic approach with a focus on co-morbidities. They account for more than 50% of all GP visits and over 70% of all in-patient bed days. Deterioration in physical status and independence in daily living can have a significant impact on both physical and mental health, social and psychological function, leading to increasing dependence on health and social care services. Effective interventions are required in the management of long term conditions to help individuals lead an active life without the need for emergency care and/or hospitalisation.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,683, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Impact still being reviewed in light of scheme 16.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- Reduction in avoidable/inappropriate A&E attendances
- Reduction in inappropriate use of out of hours services
- To promote patients independence and self-management of their condition(s)
- People feel safe and confident with management of their condition.
- More people are supported to remain in their own home.
- Reduction in admission/readmission to acute settings where appropriate
- Reduce GP visits to patients on the caseload where appropriate

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

This will be managed by the joint adult commissioning group.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*

- *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2014

SCHEME NAME :- **Social care to benefit health**	
SCHEME NO	**08**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

This is the NHS England transfer from health to social care. This fund is to be used to enhance social care services that have a direct impact on health and care for Leeds people.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

It is currently proposed that this scheme is composed of a number of different areas as follows for 14/15 and 15/16 (subject to final agreements):

Housing Care & Support - Residential Care	'There was an overall continued reduction in permanent care home admissions of people over 65 during 2013/14 and indicative data for 2014/15 suggest that admissions remain low. Placement Approval Panel data shows that there have been 68 fewer placements approved between April and September, and 63 fewer coming from hospital, compared with the same period last year.'
Housing Care & Support - Home Care	Home care hours: there is a significant growth in home care hours. ASC are paying for an extra 50 hours per week since April. One identified cause is the discharges from hospital. Analysis shows that in the first quarter discharge delays are falling quite dramatically. At current trends the financial pressure for externally procured homecare is £2.6m.
Early Help and Intervention - Therapeutic Social Work Team	Expand the Therapeutic Social Work Team
Workforce, Education and Training - Outcomes Based Accountability and Restorative Practice, City-wide Implementation and Training Programme	Restorative practice is a whole system approach about building, maintaining and repairing relationships with the fundamental premise that people are happier, more co-operative and productive, and more likely to make long-term positive changes when those in authority do things with them, rather than to them or for them. Restorative

	Practice can help to build social capital and a sense of community in all settings, from schools, children's homes, health, police, social care, partnerships and communities and through which all partners can have a common approach that cuts across disciplines to work and improve outcomes for children, young people and families.
Information and Knowledge - Social Care Records System	Exploiting the opportunities of the new 'Framework' system to allow access to critical safeguarding information about individual children securely and appropriately within hospital settings and significantly improve information sharing, reduced duplication and co-ordinated care and referrals across partner agencies.
Better Lives - Early Retirement/Severance	Voluntary Early Retirement/Voluntary Severance: in transforming services, there is the necessity to downsize the workforce, last year ASC incurred severance/early retirement (one-off) costs of £1.7m. In 13/14 £250k has already been spent on severance/early retirement, principally representing community support, day services and residential homes services. The anticipated in-year financial cost is anticipated to be £1.0m. The removal of these posts is expected to deliver a financial efficiency within 5 years of the initial one-off costs
Housing Care & Support - In-house Older People's Day Centres	The older person's day services are currently running at 54% of capacity. Although phase 1 of the strategy has been implemented including a number of closures of existing centres, further plans are being developed to more closely align future capacity with both current and likely future demand. The level of voids, during this transitional period (46%), equates to approximately half of the direct running costs of the day centres (£1.2m)
Housing Care & Support - In-house Older People's Residential Homes	The in-house residential homes service is currently running at a void level of 58 beds (14 % of permanent beds); this is equivalent to 2 whole residential homes. The annual, average, net direct cost of 2 residential homes is £1.2m (net of assumed client contribution and excluding departmental and corporate overheads and capital charges).
Housing Care & Support - Learning Disability Day Centres	The learning disability day centre review (Fulfilling Lives) has incorporated an additional £0.5m pump-priming funding to develop third sector provision. Whilst developing and supporting the transition of service users to these new services the Authority is supporting voids at 17%, this equates to £0.9m of the direct cost of providing day services for learning disability service users during this transitional phase.
Housing Care & Support - In-house Older People's Residential Homes	The older people's residential review has necessitated a 'Task & Finish Team' of care managers and social work assistants to assess the needs of all the clients affected by the transformation of services. The cost for the 2013/14 year is estimated at £0.2m.
Integration - CareTrack	The CareTrack system is starting to provide very valuable information across the health and social care system to inform activity planning and financial modelling. LCH and the CCGs are starting to identify the benefits of this

	information. The costs for licenses, data input and analysis, including a significant input of staff time, is estimated to be up to £200k.
Integration and Partnership - Increasing support for parents with drug and alcohol and Mental Health Issues	Dedicated resource to work with partners in Adults Social Care and Health to support families who are experiencing issues around drug and alcohol misuse.
CAMHS service risks	*To support to the jointly commissioned CAMHS service; this is to ensure that a rigorous review will identify the safest method of delivering the required saving on a recurrent basis (as set out in the LA children's budget setting).*
***JADAR** apply agreed formula to current caseload*	*This pays in full the 2013/14 health contribution for children on the JADAR caseload.*
***Early Help and Intervention** - Family Group Conferencing*	*Linked to the whole Restorative Practice approach, expand Family Group Conferencing to ensure a consistent city-wide offer where children and families are supported.*
***Early Help and Intervention** - Kinship Care Teams*	*Linked to Restorative Practice, the expansion of Family group Conferencing and the Kinship Care offer, to expand the Kinship Care Team to ensure that adequate support is in place to maintain positive outcomes and prevent escalation.*
***Early Help and Intervention** - Targeted locality-based Services*	*Build on the strong foundation of the Children's Centres and Early Start Service. Continue to invest in targeted evidence-based services that make a long-term difference to children and families, such as Multi-Systemic Therapy, Signpost Family Intervention Programme and Family Intervention Services*
***Integration and Partnership** - Children with Complex Needs*	*Integrated education, health and care planning particularly around transitional planning for children with a statement of Special Educational Needs with direct links to the introduction of personalised budgets.*
***Child-Friendly City** - putting children and young people at the heart of everything that we do.*	*Leeds is committed to becoming the best city in the UK and as part of this vision to become the first truly child-friendly city in the UK. Across partner agencies we need to demonstrate how we listen and involve children and young people.*
***Vulnerable Children** - Children at risk of sexually harmful behaviour*	*Dedicated resource to work with children and young people who are at risk from sexual exploitation or sexually harmful behaviour.*

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our

Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This is the NHS England transfer from health to social care and will be used to fund existing schemes. This is a recurrent scheme and we do not expect that it will have a benefit over and above the current set of Leeds baseline performance against the BCF metrics.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 12,417k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The key aim of this scheme and the sub schemes is to protect social care capacity.
The details for each of the components of this scheme are currently being developed.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The details for each of the components of this scheme are currently being developed.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Will be managed through the Joint Adult Commissioning Group

PROPOSAL IMPLEMENTATION PLAN

- *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- Disabilities facilities grants – Rob McCartney providing more info	
SCHEME NO	**09**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Bridget Emery**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Disabled Facilities Grants (DFGs) are a mandatory entitlement for disabled people to adapt their homes to create an accessible living environment. Every housing authority has a legal duty to deliver adaptation schemes where such works are considered 'necessary and appropriate' to meet the disabled person's needs and it is 'reasonable and practicable' to make the changes to the person's home.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

A local authority receives the government funding to help fulfil the legal duties of the housing authority. Adaptations play an important role in helping disabled people to live independently and therefore reduce the likelihood of hospital or residential care placements; DFGs are therefore an important intervention towards meeting Leeds' BCF plan objectives.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*

- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,958, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

This is a recurrent scheme and we do not expect that it will have a benefit over and above the current set of Leeds baseline performance against the BCF metrics.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*

- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Work is currently underway to understand this.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

This scheme relates in interventions on an individual level and run through the year. Target timescales are set for individual adaptation works to be completed with different timescales set for work based upon a priority status. The time measure is between first date of approach and date of practical completion. The local timescales for Leeds are significantly more demanding than those set out in adaptation government guidance.

PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2016

SCHEME NAME :- Social Care Capital Grant - Care Act (2014)	
SCHEME NO	**10**
RESPONSIBLE GROUP	Care Act Programme Board
ACCOUNTABLE LEAD OFFICER	Sukhdev Dosanjh, Chief Officer Social Care Reform, ASC
BUSINESS CASE AUTHOR/S	Jason Beavors
VERSION & DATE	**Ver** : 0.1 (Draft) **Date** : 10/09/2014

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

The Care Act 2014, which has been described as the most significant change to the care and support system in over 60 years, places new statutory duties on Leeds City Council from 1st April 2015.

In addition to the statutory duty the Care Act brings to the authority, a clear strategic vision for health and social care has been set out in the 'Department of Health's Information Strategy' which is fully aligned to the Government's IT strategy and 'digital by default' agenda. Leeds, as a city, has a successful integration programme in place with our Health partners to deliver part of this strategy. However, there are some ambitions set out by the Secretary of State that need to be supported by the modernisation of services. The key ones relevant to this paper are :

- Transactions – focusing on the modernisation of services to bring the system up to the standards people expect in today's online society
- Reduced administrative burden – reducing the time front line services spend on administering systems and complying with data requirements

To enable the Council to successfully fulfil the additional duties and deliver the vision will require significant change to information management and technology systems. Without the investment required to implement these technology changes, the Council will not be able to deliver the requirements of the Act and maintain the current quality of services currently provided to the citizens of Leeds. This is due to the anticipated rise in demand for assessments, care and support services, and information as a result of the implementation of the Act.

Leeds City Council Adult Social Care is working at a regional and national level with a number of external partners and stakeholders to identify opportunities to provide care services in innovative and cost effective ways. This has been recognised by the selection of Leeds to be assigned pioneer status to assist in enabling the city to go 'further and faster' to ensure children and adults experience high quality and seamless care. The development of modern online solutions as part of the Care Act implementation will provide a platform upon which to progress some of these potential initiatives such as self-management of health and social care. Please note that the funding for these initiatives is not included in this paper.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:
- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*

- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

It is anticipated that the Care Act 2014 will bring a rise in demand for assessments, care services and information. This is in addition to new requirements such as the care cap and the provision of care accounts to monitor progress towards the cap.

The Council is currently developing and implementing a new Case Management System (CIS) and earlier known requirements for the Care Act have been included in this design. However, the CIS system is only a component of the overall technology required to enable the Council to deliver the Care Act.

To enable the Council to meet the anticipated increased demand and new duties, it is proposed to develop self service solutions including online options for self-assessment, online requests for service, online review of personal care accounts, online access to care assessments, etc. To deliver these online services will require investment in the development of electronic forms, interfaces between multiple systems to enable citizen access to consolidated personal information, links to external data sources to increase the breadth and consistency of advice and information, and the introduction of electronic methods of data transfer of care information between authorities.

Another advantage of developing these online options is the flexibility of access this will provide service users, carers, and other people involved in their support and wellbeing, to be able self-serve as much as possible.

The outputs of this workstream will be available to all citizens who need to access care services, or any advice, guidance and information associated with its provision.

The introduction of the Care Act in April 2015 places new statutory duties on Leeds City Council. Adult Social Care has included some of the known changes within the new client and case management system but this is only a single part of the solution. As a collective, the current information management and technology systems within Adult Social Care do not currently have the capability, or capacity, to enable the Council to meet the statutory duties placed on it by the Care Act. The key requirements identified as part of a review of preliminary guidance from Association of Directors of Adult Social Services Information Management Group (ADASS IMG) include :

- Systems need to be capable of scaling up to meet the potential increased demand for assessments
- Systems need to enable the recording of non-eligible needs, as well as eligible needs
- Provision of a compliant financial assessment system for service users and carers
- Provision of a care account for citizens to enable them to monitor progress towards the newly imposed care cap
- Provide citizens with a record of assessments and care plans. This could be written or electronic
- Implement workflow functionality to prompt review of care plans
- Implement interfaces that enable the transfer of key information such as care accounts, assessments and care plans between Local Authorities should citizens relocate
- Implement new ways of working for social care workers including the capture of information at point of contact with the service user or carer
- Ensure all systems have the citizens NHS number and that all correspondence includes this

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The Council has a statutory obligation to ensure compliance with the requirements of the Care Act 2014.

The impact and outcomes of the implementation of the Care Act 2014, based upon analysis of current information and knowledge, supports the view that there will be increase in the demand for care services and information. When this increased demand comes to fruition it will not be possible to continue to provide the current quality range of services via existing resources and business models. It will be necessary to provide an improved information offering and a range of online services to enable self-service as an option.

The benefits associated with this project are around cost avoidance to enable the continued delivery of quality services and information to a larger cohort of citizens within existing resource levels, supported by modern technology solutions expected by todays online society

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

The investment requested from the Better Care Fund 2015/16 is £ 744,000

This is part of an overall investment plan approved by the Councils Executive Board on the 16th July

2014 :

- £744k Better Care Fund
- £608k Capital Funding
- £300k from existing Case Management implementation project

Total : £1,652k

The estimated breakdown of this spend is :

- £0k - for essential changes to the CIS system as these are included in partnership maintenance
- £50k - Leeds only CIS developments
- £60k - IT hardware infrastructure
- £20k - External security testing of implementations
- £220k - e-form developments
- £1,302k – for resources (incl. Project Management, ICT Technical, Systems Analysis) to design and develop the following :
    - Improve and expand web content with feeds from external sources
    - Develop interfaces between multiple systems to provide consolidated view of customers care transactions
    - Develop and implement national standards and interfaces to transfer care information to other authorities.
    - Develop systems to enable the capture and management of new information requirements such as care accounts.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The key stakeholders of this proposal are :

- all people associated with the assessment and delivery of Care services within Leeds
- all citizens of Leeds who have a need to understand how Care services are provided in the Leeds, the support and options available, and how to access these.

As described earlier, the main focus of this project is to enable the continued delivery of quality of services within challenging budget parameters. It will also provide citizens with services via methids expected in a modern online society.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

As part of the implementation of the technology solutions, key reporting requirements to measure the impact and success of this project will be developed. This will enable the automatic generation of statistical data such service provision numbers, etc.

There are also existing consultation groups that will be utilised to ensure continued dialogue and engagement in the development and implementation of technology, processes and solutions that meet the needs of the citizens.

By utilizing the above 2 approaches, we will ensure that we have both factual based evidence and stakeholder input to understand the impact of the changes and enable us to build on the successes and address areas of weakness.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The key success factors for the implementation of this scheme are :

- The provision of Care services to the citizens of Leeds remains of high quality and continues to be delivered within existing resources and budgets
- The citizens of Leeds and all people involved with the provision of Care services successfully adopt the digital solutions available

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

The key risks to this proposal are :

- Citizens do not utilize the digital options and continue to request traditional resource intensive methods of service delivery
- Staff do not embrace and support the implementation of this change
- Time between publication of Care Act guidance and implementation deadlines
- There is already a significant amount of change being embarked upon within Social Care which is utilising key resources. This project will be requesting support and assistance from

already fully committed resources.

- This project has a dependency on the implementation of the Customer Contact Portal which is in the scope of the Councils Customer Access Programme. Failure or delays in the delivery of this will impact on this project.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Preparation and start up phase of the project commenced in June 2014.

The implementation is planned in 3 phases :

- Phase 1– April 2015 – This phase will implement the technology solutions to deliver the fundamental changes to assessments and eligibility criteria, and support the delivery of increased demand.

- Phase 2 Go-live – October 2015 – The key launch in this phase will be care accounts to prepare for the introduction of the care cap in April 2016.

- Phase 3 Go-live – April 2016 – The key launch in this phase is the care cap, and the technology solutions that will support the provision of this.

SCHEME NAME :- Enhancing primary care	
SCHEME NO	**11**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Gordon Sinclair**
BUSINESS CASE AUTHOR/S	**Kirsty Turner, Gina Davy, Sue Jones/Deborah McCartney**
VERSION & DATE	**V4 17/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME:
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

We want frail older people and other patients with complex needs to be cared for and well managed at home, where clinically appropriate, and to experience an improvement in the quality of care received.

Services that deliver these outcomes for frail older people and patients with complex needs should deliver a range of benefits that patients have told us are important. We believe our member practices are best placed to identify the specific practice and locality level services and interventions to achieve these outcomes and patient benefits.

From 2014/15 the 'Proactive care programme' element of the GP contract incentivises General Practice to take a case management approach to the top 2% high risk and vulnerable patients on their practice registers. Simultaneously, NHS England's 2014/15 planning guidance, 'Everyone Counts', set out an expectation that CCGs should commission services to improve care for frail older people and those with complex needs. We think that these complementary commissioning requirements provide a huge opportunity for the Leeds CCGs to work together with member practices to commission locally appropriate primary and community services which ensure our older populations and those with the most complex needs and cared for and well managed at home, where possible and clinically appropriate.

The specific objectives of the scheme are to:

- support and enable further integration of health and social care working around the needs of the patient.
- ensure people are cared for and well managed at home and therefore reduce the number of emergency admissions to hospital.
- improve the quality of care for frail older people and people with complex needs.
- support and maximise the delivery of the Proactive Care Programme.
- strengthen primary care for a move of services from secondary care into the community.
- support collaborative working and learning between member practices and CCGs.
- identify learning and best practice to share across the CCG and city.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

We have worked closely with member practices to understand what *additional*primary and community care will enable delivery of pro-active care for our local populations of older people and those with complex needs, that is both effective and outcome drive. Based on this clinically led engagement, CCG localities have identified the specific interventions that they feel will have the greatest impact on supporting frail older people and those with complex needs.

As CCGs, we have each commissioned additional primary and community schemes to support older people and those with complex need in 2014/15. Working together, we will test, evaluate and refine the range of interventions commissioned through our respective 2014/15 schemes to help inform the range of primary care interventions we commission as part of this 2015/16 Enhancing Primary Care Scheme.

The specific interventions, service change and new ways of working to be commissioned through this Enhancing Primary Care Scheme will vary by General Practice/locality and commissioning CCG. Examples may include:

- commissioning general practice to provide primary care based clinical care coordinator roles to deliver effective care and case management.
- commissioning general practice and other providers to provide additional multidisciplinary primary care clinics for the proactive care of local practice populations with specific complex needs.
- commissioninggeneral practice and other providers to provide additional primary care capacity to provide more in-depth and joint consultations with patients, carers and/or members of Integrated Neighbourhood Teams.
- commissioningLeeds Community Healthcare to provide additional capacity within Integrated Neighbourhood teams to enhance integrated support across primary care, community care and third sector within specific localities.

Depending upon the intervention commissioned, the scheme will be delivered by members of primary care, community services, voluntary and community and faith sector groups in a variety of venues which may include patients' homes, general practice and community venues.

The interventions we put in place willdesigned to explicitly support, complement and enhance the Proactive Care Programme. At the time of writing, we are exploring how we could potentially work with NHS England to locally shape the 2015/16 Proactive Care Programme alongside the Enhancing Primary Care Scheme to align and integrate these work streams as part of our broader co-commissioning agenda.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The Enhancing Primary Care Scheme will be commissioned by Leeds North CCG, Leeds South and East CCG and Leeds West CCG through clinically-led commissioning processes and engagement with member practices.

The interventions being commissioned through the scheme are likely to be provided predominantly by general practices working closely with Integrated Neighbourhood Teams, community services and local Voluntary, Community and Faith Sector Groups. In some cases interventions may also be commissioned directly from Community services and Voluntary, Community and Faith sector groups.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence youhave consulted to plan your approach to integrated care overall]*

There is a requirement nationally that CCGs will provide additional investment to support improving the care to patients aged 75 or older. The 2014/15 Planning Guidance "Everyone Counts – Planning for Patients 2014/15-2018/19" states:

"CCGs will be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice, which broadly equates to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund. "

Guidance contained within Publications Gateway Reference 01414 "A Programme of Action for General Practice" stated that;

"CCGs should be using this funding to commission additional primary care services or community health services (over and above those provided under the new enhanced service) that you and other practices in your area have prioritised. It is important that you work closely with your CCG to make the best use of this £5 per patient. Any practice plans should complement the initiatives planned through the Better Care Fund for 2015/16, for which one of the criteria is an accountable professional for integrated packages of care".

In 2014/15 each CCG has commissioned additional primary and community schemes to support older people and those with complex need in 2014 to the value of £2.64 per head of registered general practice population. This complements additional clinical commissioning schemes commissioned from general practice at £2.36 per head of registered population to make up the nationally required £5 per patient stated above.

The primary and community schemes we have commissioned (using the £2.64) in 2014/15 to support older people and those with complex needs have been developed through extensive engagement with our member practices and in response to key themes and priorities identified through service user and carer engagement at CCG and citywide level. Service user and carer engagement has identified a range of patient-level outcomes that the initiatives commissioned through the Enhancing Primary care Scheme aim to achieve. These are that patients:

- have one contact person (care co-ordinator/named GP) totake a lead in making sure care plans are followed and care is delivered
- don't have to see as many professionals and repeat their story
- who may need admitting to hospital have a reduced length of stay and are seen swiftly
- feel better supported and are able to meet the demands of their caring role
- who are isolated have wider support put in place through the 3rd sector
- feel confident in managing their care if an exacerbation occurs
- know who to contact and what is happening next in their care
- feeling listened to and well supported

The evaluation of the primary and community interventions we have commissioned (using the £2.64) in 2014/15 will be central in determining the initiatives to be commissioned through the 2015/16 Enhancing Primary Care Scheme. The metrics being used to evaluate each of the interventions being commissioned in 2014/15 vary considerably by intervention being made. However, in planning and monitoring evaluations, practices are encouraged to work as a locality to share planned approaches, learning and emerging results.

Over the course of 2014/15, as CCGs, we will track system-wide BCF indicators at CCG level. The three Leeds CCGs will collectively measure these indicators to understand progress towards these across the CCGs. These are:

- patient / service user experience
- avoidable emergency admissions

It is recognised that it is not possible to attribute a causal relationship between practice-level interventions and the system-wide BCF indicators that the CCG will collect. However it is anticipated that the initiatives and services commissioned in 2014/15 will contribute, alongside the Proactive Care Programme Approach and other initiatives, to the system-wide BCF indicatorsand supplementary measures have been developed to track this contribution.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,141, 000 as calculated by £2.64 per head of CCG registered population. Breakdown as follows:

Leeds North CCG £545,136
Leeds South and East CCG £678,480
Leeds West CCG £924,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Through the Enhancing Primary Care Scheme primary and community services will be commissioned to deliver services and interventions to achieve the following outcomes:

1) to ensure frail older people and/or those with complex needs are cared for and well managed at home where clinically appropriate.
2) to ensure frail older people and/or those with complex needs experience an improvement in the quality of care they receive.

In turn, it is anticipated that these will contribute to the following citywide system indicators and overall achievement of the following overarching outcome of the Better Care Fund:

- improved patient/service user experience
- reduction in avoidable emergency admissions

The relationship between the Enhancing Primary Care Scheme the contribution to citywide indicators is demonstrated in the diagram below. As CCGs, we will assess whether Leeds as a health and social care system is making progress towards achievement of the system and BCF outcome as quantified through the citywide indicators below. It is not possible to attribute a direct causal link between individual practice-level interventions and the achievement of citywide indicators. Practices will however be required to use information and data to evaluate the extent to which the planned intervention or service have delivered the contribution which they set out to make – please see Figure 1

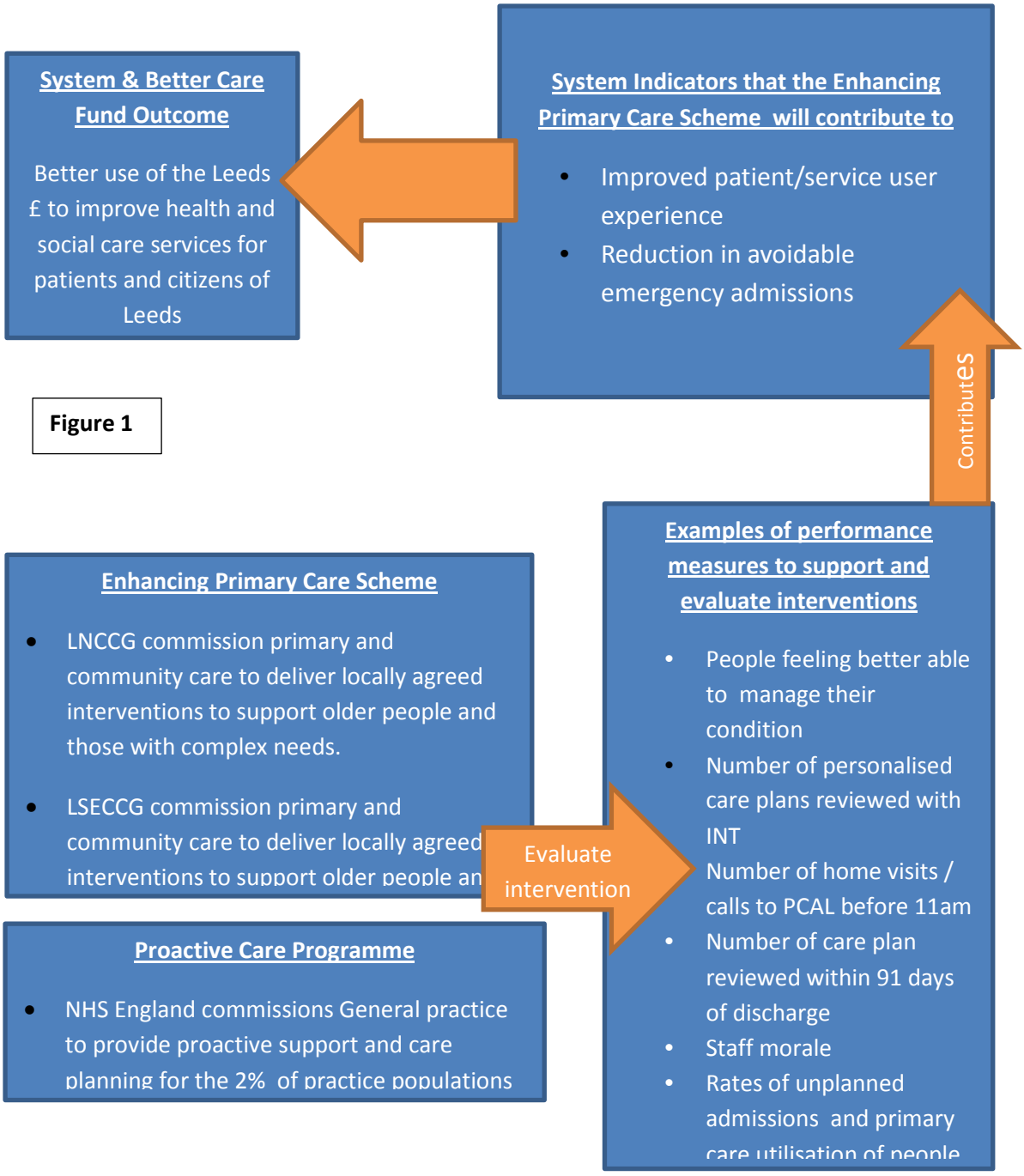


Figure 1

As previously stated, the evaluation of the primary and community interventions we have commissioned (using the £2.64) in 2014/15 will be central in determining the initiatives to be commissioned through the 2015/16 Enhancing Primary Care Scheme. As these interventions are only just commencing, and yet to be evaluated, it is not yet possible to anticipate the impact on local performance measures or the contributory impact on the system indicators of improved patient experience and reduction in avoidance emergency admissions.

In the absence this information, based on modelling undertaken by Dr Tom Mason, it can be assumed that this scheme will support primary care to put in place care plans for their top 2%

populations, the benefit being that by going through this process the unplanned hospitalisation risk for these patients will fall be between 5 and 10 %. This is a relatively conservative assumption that translates into around 1,000 avoided admissions to hospital each year across the city.

Assuming the vast majority of patients being managed under the scheme are 65 and over, the reductions in admissions may be expected to reduce the total number of elderly patients being admitted to hospital by between 1.3 and 3.5% (based on the success of the scheme). Assuming a one-to-one relationship between admissions and DToC, this translates into DToC of between 240 and 640 lost bed days per year.

Through the interventions commissioned through the Enhancing Primary Care scheme, we aim to have an impact on reducing emergency admissions through the effective and pro-active case management and ensuring that admissions are avoided through care planning.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Each intervention commissioned through the Enhancing Primary Care Scheme will establish arrange of performance measures to measure the impact of the given intervention. Performance measures will vary by intervention but may include:

Patient performance measures:

- Patient reported ability to manage their own health
- More effective/ reduced duplication in visits from members of Integrated Neighbourhood team/GP Practice
- More comprehensive care plan, supported by VCF sector organisations

Practitioner performance measures

- Reported improvement in working relationships across primary care and Integrated Neighbourhood Teams
- Staff morale

System measures

- Patients better supported by VCF sector
- Attendance and input of Integrated neighbourhood team in case management meetings
- Number of emergency admissions and readmissions

To enable comparability across different interventions commissioned, all interventions will utilise patients experience measures and also measure the number of emergency admissions across the patient cohorts supported through the given intervention.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*

- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Work is currently underway to understand this.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Risk	Mitigation.
Workforce; There is a risk that the appropriate workforce is available with specific skills	The interventions commissioned in 2014/15 (which will inform which interventions are commissioned in 2015/16) have been developed and discussed in partnership with general practices and Leeds Community Healthcare thus reducing the development of interventions based on a non-existent workforce.
Delay in implementation; There is a risk that the time taken to establish interventions commissioned in 2014/15 will result in a paucity of performance measures to determine which intervention have had the greatest success.	Consideration of the the continuation of interventions commissioned in 14/15 into 15/16 to establish sufficient information to enable appropriate evaluation of individual interventions.
Links to other providers; LCH/ASC may have already developed their plans (as part of the BCF) and General Practice may be excluded	The CCG is actively engaged in the LCH CQUIN Implementation Group and is ensuring that primary care is appropriately represented to ensure that all plans support integration.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

TBC

SCHEME NAME :- Redesign of dementia pathway and creating "Eldercare Facilitator" role	
SCHEME NO	**12**
RESPONSIBLE GROUP	**Tim Sanders with Brian Collier (Transformation Director) Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris / Ian Cameron – LTC**
BUSINESS CASE AUTHOR/S	**Tim Sanders**
VERSION & DATE	**9th September 2014 – v2**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Leeds dementia strategy objectives:

More people with dementia will be diagnosed, at earlier stages of the condition, and this will lead to better support and quality of life.

People living with dementia alongside other health conditions and disabilities, will have integrated support to maintain emotional, psychological and physical well-being.

To create holistic management of dementia and comorbid physical and mental health conditions; and provide early support to promote well-being and independence (National Dementia Strategy, NICE clinical guideline). Improve quality of life with dementia (NHS Outcomes Framework 2.6ii / Adult Social Care Outcomes Framework 2F).

To bring memory assessment, diagnosis and management of dementia into the GP practice setting, to improve access and reduce stigma associated with the condition; whilst maintaining the role of specialist clinicians in memory assessment and diagnosis, and ensuring ready post-diagnosis access to specialist services as required in response to need.

Create the role of "eldercare facilitator"[1], one FTE for each of the 13 neighbourhoods, to work as part of primary care team, providing post-diagnosis follow-up. The role could be provided by third sector or an NHS provider, and will require 'honorary contracts' to work effectively within practices and share information.

To design a "Year of Care" holistic review process for people living with dementia, including any medication monitoring once prescribing is initiated and stable. This would remove duplication between memory service review and GP QOF review; focus on support for the person to live well, rather than cognitive test scores.

To sustain and accelerate the trend of improvement in dementia diagnosis rate (NHS Outcomes Framework 2.6i).

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*

[1] This job title is used for a similar role developed by Dr Ian Greaves and colleagues at Gnosall and rolled out across Stafford and Cannock CCGs. Cconsultation with people living with dementia and carers in Leeds indicates a strong preference for an alternative title, to be clearer about the role.

- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The Eldercare Facilitator role will be mainly post-diagnosis: to befriend and build trust; support people to come to terms with living with dementia and what this means for each person; to inform and connect people and carers reliably and consistently to post- diagnosis support. Local evaluation[2] has shown we often fail to link people to the range of support and services available in Leeds.

This means, per full-time equivalent, being a named point of contact for 400-450 people living with a diagnosis of dementia. Intervention is focused initially on the immediate post-diagnosis period, an average of 100-120 people per FTE per year. This will take place mainly at home visits.

Old age psychiatry and memory service clinic sessions to take place in GP surgeries (initially one location in each of the 13 neighbourhoods) working as virtual teams with GP practices and eldercare faciltator. The estimated capacity required for the whole of Leeds is 83 half-day sessions per month, shared between the team of old-age psychiatrists and specialist doctors.

Revise memory service specification to: facilitate this closer link to primary care; include a standard of post-diagnosis education and non-drug treatment (eg. cognitive stimulation therapy); and simple access back to the service when needed.

Review local guidance for Donepezil and other Alzheimers medication. To remove unnecessary tasks from the monitoring process (given that ongoing prescribing is less of an issue now that costs have reduced significantly); make clear the requirement to use Donezepil as most cost-effective AChEI[2] option, unless contraindicated; describe when specialist services should become involved again.

The Eldercare Facilitator will support self-management plans and case management interventions, a resource to support the capacity of primary care, help implement interventions eg. arising from the unplanned admissions DES, and the Integrated Neighbourhood teams. They will therefore have an impact to reduce acute admissions and readmissions. There will be more capacity for practices to stay in touch with people and monitor situations, rather than people 'falling off the radar' until an emergency happens.

The redesign will bring the expertise of specialist services and primary care together to achieve integrated care for people with dementia and co-morbid conditions linked to ageing, and strengthen formal and informal links between clinicians. It will avoid the duplication / fragmentation arising from Alzheimers medication reviews at a memory clinic; whilst primary care carries out annual dementia reviews (QOF DEM2). It will end the inappropriate, prescribing- led, variation in post-diagnosis information and support.

The specialist nurses and OTs in the Leeds memory service will be released from routine reviewing to reduce waiting times for memorya ssessment; to deliver post-diagnosis education and treatment; and respond to re-referrals when there are significant changes in eg. a person's dementia, social circumstances, behaviour.

Leeds City Council (adult social care) will tender for the Eldercare Facilitator service, and there is known interest from local third sector providers as well as scope for NHS providers to bid.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

[2] Dementia In Leeds Evaluation project 2013, available to download from www.leeds.gov.uk/dementia

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The delivery of the redesign is overseen and co-ordinated by a Working Group, chaired by Nicola Dumphy, clinical lead for mental health, dementia and LD for Leeds S+E CCG; and supported by Tim Sanders, Commissioning Manager for Dementia, a joint health and social care post employed by Leeds City Council. The group includes old-age psychiatry lead (Wendy Neil), medicines management (from commissioner and specialist provider), Practice Nursing lead from Leeds North CCG, commissioning managers responsible for locality working from all three Leeds CCGs, the local Alzheimers Society, Leeds Involving People, and support from the regional Strategic Clinical Network.

Leeds North CCG is the lead commissioner for the contract with Leeds and York Partnerships Foundation NHS Trust (LYPFT) and the development of the service which forms part of this redesign is part of the agreed service specification.

Leeds City Council (LCC) is starting the procurement process for the Eldercare Facilitator roles – at the time of writing, a timetable is awaited from LCC procurement unit. However, it is anticipated that contract award will be in January 2014. Tim Sanders is leading on the procurement.

Heather Edmonds (Leeds North CCG) and Anita Solanki (LYPFT) are the medicines management leads reviewing the local 'amber drug' guidance for the three anti-cholinesterase inhibitors prescribed in dementia, and memantine.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The Leeds Dementia Strategy (*Living Well With Dementia In Leeds*, 2013) set the local direction for closer working between specialist services and primary care; connecting the ambition to increase diagnosis strongly to that for post-diagnosis support (so diagnosis is not reduced to chasing numbers); a review of patient and carer experience, and review of 'shared care' for dementia medication. The evidence base included:

- Leeds GP register data showing that 90% of people with a dementia diagnosis had at least one other long-term condition;
- Leeds Memory Service activity (contacts per year) had increased significantly whilst waiting times had increased to April 2013, fitting the clinicians' view that a disproportionate part of their activity was routine reviewing.
- Innovations elsewhere in the country improving diagnosis and post-diagnosis support by implementing primary care based models.

The evaluation of experience on the dementia pathway was published in September 2013[3]. This identified that carers especially valued the diagnosis in its own right, as making sense of changes and behaviours; but that people often felt left 'high and dry' after a diagnosis. The project tested out people's views on increasing the role of GP practices, and indicated that, whilst some people would welcome the opportunity to be supported closer to home, there was concern about loss of specialist support. It was pointed out that the ambition for early diagnosis favours the continuing role of specialists.

Commissioners appraised options for primary care models, based on three from elsewhere in England:

a. Bristol – GPs have taken on more diagnosis and initation of prescribing, supported by a primary care liaison service. Not favoured because not backed widely by local GPs,and old-age psychiatry acknoeledged as able to diagnose more accurately at earlier stages. However, it was agreed that Leeds should increase GP role in diagnosis at later stages, as described in Joint Commissioning Panel guidance[4]; people can remain undiagnosed if GPs decide not to refer frail older people with more advanced dementia to memory services.
b. Hastings, Sussex – primary care memory clinics run by GPs with Special Interest in Dementia. It was felt that we already have the right clinical expertise available, and if anything GPs with SI are more expensive. The training provided by Bradford Dementia Group was offered to local GPS, including funding for practices to backfill, but there was no interest expressed.
c. Gnosall – old-age psychiatrist provides a monthly memory clinic on the premises of the local GP practice. Eldercare Facilitator supports memory assessment and post-diagnosis. This was agreed as the basis of our preferred model, based on making best use of clinical expertise and addressing the issue of post-diagnosis support. However, the existence of qualified specialist nursing and OT within the memory service is a strength that Leeds enjoys, and we do not wish to lose this from the early stages of the dementia journey, or the opportunity for closer working with community services.

The final proposals were tested out in consultation with people living with dementia and carers; GPs; and all partners via the Leeds Integrated Dementia Board.

The Gnosall model has been in operation for seven years and has now been rolled out across two CCG areas – Stafford and Surrounds, and Cannock and Surrounds, with 280,000 population. Published evidence points to very high patient and carer satisfaction; and 100% of expected prevalence either diagnosed with early memory problems, or actual dementia. Michael Clark at London School of Economics has reviewed acute admissions data and identified that Gnosall surgery's spend on acute admissions is £450K below expected average for population profile for 8,000 population, with Eldercare Facilitators linked to a range of primary care initiatives re. dementia and frailty[5].

In Leeds, there has been initial analysis of hospital admission data, divided into subsets identified by the national dementia CQUIN for acute care. This enables us for the first time to compare inpatient episodes (primary diagnosis, length of stay, admission tariff, cost) according to whether dementia was already diagnosed on admission; or memory problems identified by the CQUIN; or no dementia indicated.

There are c. 3,800 people aged 75+ in Leeds with a diagnosis of dementia in Leeds, with an estimated

[3] *Dementia in Leeds Evaluation Project,* available at www.leeds.gov.uk/dementia
[4] RCGPs / RCPsych, www.jcpmh.info/good-services/dementia-services/
[5] http://blogs.lse.ac.uk/healthandsocialcare/2013/05/07/putting-personalisation-and-integration-into-practice-in-primary-care/

average probability of 50% for an acute admission each year. The leading primary diagnoses for this cohort are urinary and respiratory infections, falls and fractures, which are all regarded as potentially preventable causes[3].

The analysis of local data suggests that:

- 2,400 admissions were identified for people with dementia diagnosed or suspected, out of 8,900 total for people aged 75+; this is an underestimate given that it does not include admissions where the CQUIN process was missed.
- people with dementia are estimated as 13% of the general population aged 75+; but are almost 40% of those admitted with falls and / or fractures; and almost 45% of the bed-days and costs of those admissions.
- Average cost per admission of a person with dementia / memory problems is c. £4,000.
- Average length of stay was 2 days greater for people with dementia or memory problems; however, this did not usually exceed tariff 'trim-point' because people were allocated to more complex tariffs.

This tells us that:

- there is a need to fully include people with dementia in admissions avoidance initiatives and that the primary causes are among those commonly identified as preventable.
- the Eldercare Facilitator role can provide capacity to support reduction of admissions, including readmissions, forming the basis of an "invest to save" case;
- people living with dementia have a strong likelihood of being in the "top 2%" of people at risk of rising care costs, and on the 'caseload' of Leeds Integrated Neighbourhood Teams. Although they are envisaged as part of the primary care team, the allocation to each of the 13 neighbourhoods will enable strong links to develop, to support transitions from' self-management' to 'case-management', and back again.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£435K to employ 13 Eldercare Facilitators (c. Band 4 / unqualified social work equivalent) plus a manager role, including on-costs.
£130K to pay GP practices for accommodation and support for memory clinics, admin and other work. (£10K pa per neighbourhood).
BCF TOTAL - £565K pa.

Additional resource available: dementia and workforce funding carried over from 2013-14 to support Eldercare Facilitator and primary care training. c. £25K one-off funding.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

On patient experience:

- shorter journeys and reduced stigma from service delivery in nearby primary care setting.
- direct booking into memory clinic via primary care system without delays caused by referral admin.
- access to post-diagnosis support from dedicated staff role, which has not been available for people with a vascular dementia and others not prescribed dementia drugs.

On Activity :

- This will impact of acute admissions and contribute significantly to "Everyone Counts" requirement to reduce acute admissions by 15% over 5 years.
- 2015-16: 1,200 people with dementia with preventive person-centred plans in place – 200 fewer acute admissions.
- 2016-17: 2,500 people with dementia with preventive person-centred plans in place – 400 fewer acute admissions
- Further impact over 3-5 years from getting better at preventive care planning; and longer-term effects of increased diagnosis and early support.

On Cost :

- Average cost per admission is £4,000 identified from above work on Leeds Teaching Hospitals admissions and dementia CQUIN data. To be conservative, this calculation uses a figure of £2,000 per admission to allow for other services and investments contributing to admission avoidance.
- 400 acute admissions therefore corresponds to £800K savings.

Impact on BCF National Conditions / BCF Performance targets

+ Protection of Social Care: not a direct support, but indirect effect of relieving workloads.

7 Day working: capacity above would probably be too little for 7-day availability.

+ Accountable Lead Professional: would sustain and support self-management cohort and smooth transitions to case management and back to self-management.

++ Impact upon Acute Sector: this cohort of patients are among those who fare worst on acute pathways, with moves through A+E, MAU to ward and assessments at each step.

++ Emergency Admissions: evidence of prevalence of potentially preventable admissions. Delayed Discharges

+ Effectiveness of Reablement: offers support for step-down from intermediate care to daily living.

+ Local measures: increase dementia diagnosis rate (though this will be after the timescale for the March 2015 ambition to get to 67% of estimated prevalence).

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

The proposal aims to achieve improvements in experience of people living with dementia, including families and carers; integrated working and mutual support between primary and secondary care; and reductions in avoidable admissions to hospital. This will require a range of

measures that cover both service outcomes and population outcomes. The Leeds programme for adult integrated care uses the Outcomes-Based Accountability approach. The Strategic Clinical Network dementia lead has agreed to discuss evaluation of the redesign with the Academic Health Science Network (AHSN).

Metrics will include:

- patient and family carer experience, eg. satisfaction with timeliness, and quality.
- clinician experience of new working arrangements.
- Eldercare Facilitator reports of involvement in preventive care plans
- individual narratives, including counterfactuals of likely outcome prior to intervention.
- subset of acute admissions for preventable causes for people with dementia diagnosis and memory problems; admission costs , lengths of stay.

These will require new surveys and data collections; and work to develop a dementia "subset" of hospital admission data.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- The commitment of all partners, based on strong networks governed by Leeds Integrated Dementia Board, and the level of engagement and negotiation involved in the design of the proposal.
- The continuing high priority attached to dementia care, nationally and locally, underpinning the commitment of colleagues from eg. medicines management, CCG locality teams.
- The programme design under the Leeds Transformation Board, enabling links to be made between long-term conditions, primary care development and admission avoidance.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- lack of accommodation for clinics in primary care, therefore prioritising one clinic location in each of the 13 neighbourhoods;
- IT system requirements and timescales for any improvements. Early discussion with timescales in parallel with procurement process for eldercare facilitators.
- GP practices might not trust Eldercare Facilitators with sensitive data and therefore withhold 'honorary contracts'. Include quality assurance and compliance standards in provurement process, and involve GP representation on evaluation panel if possible.
- Some old-age psychiatrists might resist moves to primary care clinic locations. Reassure re. relatively small number of monthly sessions; consider keeping community arrangements where they exist already, with alternative ways of engaging with primary care.
- pressures on primary care will affect GPs' trust and acceptance of new working arrangements eg. represcribing dementia drugs without memory clinic recommendation. Ensure new arrangements take GP and practice nurse workloads and training needs into account, and offer clear pathway to specialist advice and services when required.

- delays in taking routine reviewing from memory service will limit capacity to see new referrals promptly.
- impact of early and preventive support is difficult to track and quantify. Track chain of causation via involvement in preventive care plans.
- people with dementia and families may choose to attend A+E even when care plans and management are in place, especially if person presenting with delirium.
- increased cost of eg. domiciliary services and intermediate care services meeting needs outside hospital

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Start date: August 2014.
Redesign implemented: spring 2015
Evaluation: summer and autumn 2015.

Eldercare Facilitators:

- procurement timetable set – September 2014
- out to advert – c. October 2014
- selection of provider – January 2015
- staff in post – March 2015
- training programme – March / April 2015.

Memory clinics in primary care:

- identification of venues: Sept – Dec 2014
- agreements in place with GP practices: Jan / Feb 2015
- evaluation of GP systems v requirements – Nov 2014.

"Year of Care"

- review of dementia drug guidance – Dec 2014
- design of annual review process – Feb 2015
- implementation – summer 2015

SCHEME NAME :- Medication management and memory problems	
SCHEME NO	**13**
RESPONSIBLE GROUP	**Tim Sanders with Brian Collier (Transformation Director) Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	**Tim Sanders**
VERSION & DATE	**V2, 12/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

To meet the needs of a cohort of people who cannot manage medication, and do not have informal care or care services available for support; or where there is support, carers or staff need advice or training to get medication right. To take an innovative, integrated approach involving medicines management, assistive technologies, community services and third sector. Difficulties with medication may be linked to behavioural and psychological needs in dementia and exacerbate informal carer stress.

Specific strategic links:

- Leeds Dementia Strategy – priority for diagnosis to lead to post-diagnosis and self-management support.
- Integration and the BCF as an opportunity to resolve a long-standing local difficulty.
- Self-management support for diabetes, vascular disease, hypertension – people with these conditions are at higher risk of memory problems, and problems with medication may severely exacerbate these conditions.
- Reduction of hospital admissions linked to problems with medication compliance (risks apply to both forgetting to take it; forgetting one has taken it).
- West Yorkshire Community Pharmacy sign-up to Dementia Action Alliance and commitment to dementia-friendly pharmacies.
- Leeds priority to tackle loneliness; people who have no-one to help with medication may well be isolated socially. We can link this new pathway to a range of third sector services, and developments with £6m Big Lottery funding.

Adult social care policy has for some time been to offer a medication prompt as part of a larger care package where care staff are visiting for other support tasks, but not as a standalone service. However, there is local evidence that even when this is provided, Community health services are commissioned to provide some capacity for support, but this is always below the demand for prompts.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?* I
- *Which service user/ patient group is being targeted? What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The model for the scheme is still in design, and a small, amount of BCF funding will be used in 2014-15 to work up the scheme, including one day per week for six months of Leeds Community Healthcare pharmacy technician as project support.

The group of people benefitting from the service is, broadly, anyone with memory problems which affect the ability to take the right medication – the preferred approach is *not* to apply restrictive criteria (eg. only confirmed diagnosis / dementia medication). An initial estimate is that 2,000 people per year may benefit from a person-centred approach to optimise medication and identify solutions including Telecare; 200 people at any one time needing at least one daily prompt visit at home. Further data is being sought to improve these estimates.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

It is likely that the model will involve:

- Leeds S+E CCG commissioning Leeds Community Healthcare to increase capacity of Pharmacy Technician Team.
- Leeds City Council commissioning domiciliary care from existing contracted providers, perhaps with a selection process to choose a smaller number of providers for this service.
- Leeds North CCG commissioning LYPFT to ensure specialist advice and guidance is available from the Leeds Memory Service, to develop person-centred solutions.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The Leeds Memory Service reports that it is an issue they routinely encounter in practice, that it is difficult to arrange a medication prompt so that they can prescribe Donepezil (Aricept) and other related drugs for people diagnosed with Alzheimers disease, who have no-one available to prompt medication - usually those who live alone. The memory service do always try assistive technology as a solution, with variable success.

Leeds Community Healthcare are commissioned to provide a level of medication prompting from community nursing teams, but report that this capacity is full with a waiting list, and believe they are not commissioned to provide sufficient capacity.

Leeds GP data shows that 90% of people with a diagnosis of dementia have at least one other “Year

of Care" long-term condition. Probably a greater risk to well-being is when people with memory problems (which can be linked to a range of conditions, eg. depression or nutrient deficiency as well as dementias) are prescribed medication to control eg. diabetes, hypertension, cholesterol.

The Social Care Institute for Excellence (SCIE) has reported that:

> *Forty-five percent of the medications prescribed in the UK are for older people aged 65 and over, and 36% of people aged 75 and over take four or more prescribed drugs. It has also been found that as many as 50% of older people on prescribed medication may not be compliant with the prescribed regimens, that is, taking their medicines as instructed.* [1]

NICE have stated that *the costs of admissions resulting from patients not taking medicines as recommended is estimated to be between £36 million and £196 million in 2006–07.*[2] This scales to c. £0.5m - £2m pa. for Leeds, though proportion attributable to older people and memory problems is unknown.

There is published evidence from a Leeds pilot project, in which Leeds Teaching Hospitals Trust pharmacists offered medicines review to people who *already have a medication prompt service* as part of a domiciliary care package[3]. "Recurring themes" included problems with compliance aids (Telecare), communication about changes on hospital discharge, inhaler technique for asthma, and medicines not being used (finding excess and expired medication). This suggests that elements of the new service should extend to people already receiving prompts.

Anecdotal evidence, including carer representaive on Leeds Dementia Board, of the stress involved in ensuring medication is taken.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£10K to work up during 2014-15.

Initial very rough estimate of costing:

- 2,000 people per year for person-centred planning and optimisation of meds @ £50 = £100K
- 200 people requiring daily (*365) prompt visit @ £3 = £220K

TOTAL **£320K**

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about*

[1] http://www.scie.org.uk/publications/briefings/files/briefing15.pdf
[2] http://www.nice.org.uk/nicemedia/pdf/CG76CostStatement.pdf
[3] *Domiciliary Pharmacy Technician Medicine Reviews For Patients Having Home Care Medicines Assistance*; Pharmacy Management Volume 30 Issue 1, http://pharman.co.uk/volume-30-january-2014

future outcomes?

Impact on BCF National Conditions/BCF Performance Targets

- Protection of Social Care – relieving pressure on services arising from disputed responsibilities.
- Accountable Lead Professional – would strengthen self-management arrangements and avoid some escalations to case management.
- Emergency Admissions– reduced admissions

'Intelligence suggests 90% of dementia patients have one or more co-morbidities that require regular medication. Where an individual doesn't have regular care in place there is a risk of unplanned hospitalisation due to lack of compliance with medications. We estimate this will reduce admissions by the required level to at least meet the investment.

Intelligence suggests 90% of dementia patients have one or more co-morbidities that require regular medication. Where an individual doesn't have regular care in place there is a risk of unplanned hospitalisation due to lack of compliance with medications. We estimate this will reduce admissions by the required level to at least meet the investment.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Metrics:

- Number of plans made, including counterfactual information about what risks have been managed and potential adverse outcomes.
- Number of people who cannot be prescribed Anti-Cholinesterase Inhibitors for Alzheimers Disease, because of the lack of availability of a medication prompt.
- Practice nurse / GP reports of number of patients attending for long-term condion reviwes where there are medication management concerns linked to memory / cognitive concerns.
- If we can identify a subset of acute hospital admissions which are likely to be attributable to medication non-compliance ?

These will all require work to design and capture the metrics.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and

ii) engagement with partners about the deliverability of the proposal
- Commitment to developing an integrated model rather than "more of the same". Engagement of partners through workshop on October 2nd. - Stepped approach of developing options; appraisal and design; pilot; evaluate; roll out
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
To be developed. Basically risks associated with an innovative approach.
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
Aiming for new service to start April 2015. Design period will be a few months, but commissioning is likely to be relatively modest financial changes to existing contracts rather than requiring procurement.

SCHEME NAME :- Falls Pathway scoping	
SCHEME NO	**14**
RESPONSIBLE GROUP	**Lucy Jackson** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

50K has been allocated to support the scoping of work to prevent falls and decrease admissions due to falls in Leeds . The proposal is to fund a person on fixed term basis to undertake a scoping exercise of the evidence base of preventing falls within the context of supporting older people living with frailty. They will also review the present service; identify gaps and good practice from elsewhere. The outcome will be a costed, evidence based option paper for reducing falls in older people in Leeds.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

Falls and fear of further falls are a key contributor to reducing older peoples independence – therefore by contributing to Outcome 2 of the JHWBS. The number of older people- especially the frail elderly are predicted to rise in Leeds and therefore this issue will continue to be important . Figures from POPPI show an expected increase of 15% in the number of people having falls, and injury due to falls, in those aged 65+ in Leeds between 2012 and 2020.Admissions for falls in Leeds are high, with A&E data on injuries due to falls in Leeds higher than rest of the country. There are over 1000 injuries due to falls a month. YAS call out for falls in Leeds are averaging 90 a day- for one month call per CCG were 339 calls to YAS (Leeds North); 486 (Leeds South and East),Leeds West -483. Thereby preventing falls and reducing the requirement to call YAS or for a hospital A and E attendance or admissions due falls will impact on the whole system as well as increasing the quality of life for older people in Leeds.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Funding for post – proposed Agenda for Change 7 or equivalent (if 9 months – 33K)
Funding for two stakeholder events (2K)
Admin support

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population (sub divided for 65 to 79 ; over 80s)

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

2014/15 - £50k
2015/16 - £500k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*

- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Older people (via Leeds Older Peoples Forum) ;CCGs; LCH; LTHT; YAS; Primary Care; IHSCTs (ASC/LCH)
Impact on Activity
Modelled deaths in Leeds due to falls 58; estimated hospital admission due to falls in Leeds 2495

Impact on Cost :
This is the initial scoping work but if we succeed in s business case for falls in the city **- Estimated cost of falls in Leeds - £12m**

FEEDBACK LOOP
What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME - *E.g. expertise, staff, demographics, history of partnership working.* - *Do these also exist within the local area?* - *If not – have actions been put in place to resolve this?* - *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?* - *An outline of a stepped approach to implementation which draws on* *I) learning from either local evaluation or other areas where this has been implemented, and* *ii) engagement with partners about the deliverability of the proposal*
It is expected that this scheme will have its largest impact on reducing non-elective admissions. It is likely that it will also impact on admissions to residential care. The exact size of the impact will be modelled during the course of 2014/15.
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
Will be managed by the integrated system change group.
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- *Reducing Admissions and reducing delayed hospital discharges*	
SCHEME NO	**15a & 15b**
RESPONSIBLE GROUP	Integrated Health & Social Care Board
ACCOUNTABLE LEAD OFFICER	Diane Boyne**/**Paul Morrin/ Sam Prince/ Dennis Holmes
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

To increase nursing CIC beds by 12 beds(7.5% increase of overall CIC bed provision) with the associated Neighbourhood Team staffing, allowing, approximately 140 additional patient CIC stays per annum. This will support both step up and step down to enable appropriate and timely discharge of patients from hospital and avoid admissions. This includes expanding the community bed bureau to 7 days working, to allow optimum use of available community beds and to even capacity across the week.
Total cost £650,000.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

Whole system flow
The proposal will improve whole system patient flows by providing more capacity to prevent hospital admissions and reduce delayed discharges. The increase in capacity will bring Leeds closer in line with national median benchmark of 23 CIC beds per 100,000 weighted population (Leeds currently has a steady state of 20 CIC beds per 100,000 weighted population).

Reduction in acute admissions
The proposal will also provide sufficient overall CIC capacity and flexibility to allow us to ring-fence a number of beds in the new CICU in Beckett Wing for immediate diversions from A&E and the assessment floor at SJUH. Clinician reports are backed up by recent data analysis (CCG Performance Team March 2014) that we are currently admitting to hospital on average 1.75 patients per day from A&E and elderly assessment wards who could have gone directly into a CIC bed if one had been immediately available. This equates to 420 people per year. Currently this cohort are defaulting to a full and unnecessary hospital admission (with an average l.o.s. of 4.4 days) then subsequently going on to a CIC bed on discharge from hospital.

Reduction in delayed discharges
The proposal is also intended to reduce delayed discharges due to awaiting CIC bed availability.

Geographical spread of CIC beds

In addition, this proposal could potentially allow us to provide a more even geographical spread of beds across the city (subject to market availability of beds) which would improve patient/service user choice.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

- No. acute admissions avoided(from home and from A&E/assessment floor) due to timely availability of CIC bed
- No. bed days delayed hospital discharge due to lack of CIC availability
- No. patients referred for CIC bed whilst in A&E but are actually admitted to a CIC bed from a hospital ward
- Increase in community services activity (health and social care)
- Use CareTrak to monitor longitudinal outcomes

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

the commissioning of 12 beds (FYE)	£410,000
additional LCH staffing to support the beds	£180,000
enhanced GP cover	£10,000
Bed Bureau 7 days	£50,000
Total:-	**£650,000**

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Nursing care home providers- need to provide additional capacity with a guarantee of 12-bed level of provision
- Neighbourhood teams – notably Community nursing, therapy and social work staff, primary care, Health Trainers, specialist services, voluntary sector organisations.
- Acute services – particularly in relation to interface functions e.g. discharge planning
- LCH EDAT/Interface geriatricians/A&E and assessment floor staff – awareness needed of the change to the pathway and the 'protected' CIC capacity
- LSECCG – commissioning and contracting lead on LCH contract and nursing home contracting
- Integrated Health and Social Care Board/Transformation Board – to monitor and review impact of these proposals alongside other service developments

All of the key providers will be required to work in an integrated and collaborative way centred around the patient and their personalised care plan

Impact on Activity

Reduction in acute admissions

Reduction in acute hospital admissions from A&E and the assessment floor by 420 per year

Assuming under the new pathway patients diverted from A&E direct to the CICU sub-acute ward have an average length of stay on this ward of 4 days, 7 of the 12 additional beds will also be available to support patients discharges from hospital wards (which is recognised as a pressure point for DToC). These extra 7 beds should help reduce DToC by 2,500.

Impact on Cost

Reducing acute admissions

Based on a range cost of the hospital stay for this cohort of patients of £1,500-£2,000 per stay, the current cost of these avoidable acute admissions is £630,000-£900,000 p.a.

BCF National conditions

1. **Plans to be jointly agreed.** The proposals respond to the implementation of the Target Operating Model for integrated adult health and social care services, which has been agreed at multiagency Leeds Transformation Board. **+ve**
2. **Protection for social care services.** The proposals include funding for health and social care resource as part of integrated working at neighbourhood level and to support discharge planning **+ve**
3. **7 day services to support discharge and reduce admissions.** As outlined this proposal specifically increases community bed capacity to improve patient flows across the 7 day period. **+ve**
4. **Better data sharing between health and social care based on the NHS number T**he integrated neighbourhood team model is based around a multi disciplinary team, including both health and social care, working closely together to deliver a programme of care. The NHS Number ahs been agreed as the common currency between different organisations. This work is support by ongoing developments in information governance and data sharing between health and social care organisations in Leeds, lined to pioneer status and Leeds Care Record.
5. **Ensuring a joint approach to assessments and care planning and ensure that where funding is used for integrated care there will be an accountable professional**– integrated neighbourhood teams will have a joint multiagency and multiprofessional approach to assessment and care planning, including patient and family engagement in this process. This will be supported by a case management approach, including proactive care, and named leads for patients who are being case managed within the integrated neighbourhood teams.
6. **Agreement on the consequential impact of changes in the acute sector.** The proposals outlined are designed to reduce the overall number of acute beds required and reduce length of stay through a more proactive, communit6y based response. The overall impact will be modelled at a programme level. **+ve**

BCF Performance Targets

1. **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes** – increasing community bed capacity and delivering the service as part of the integrated health and social care team will enable people to live as independently as possible for as long as possible in their own homes. **+ve**
2. **Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services**. Effective discharge management and enhancing neighbourhood teams will enable people to live as independently as possible for as long as possible in their own homes. **+ve**
3. **Delayed transfers of care from hospital per 100,000 population.** The enhanced community bed capacity will improve flow from acute to community settings reducing DTOC. **+ve**
4. **Avoidable emergency admissions** – community beds will enable people to be maintained in a community setting, avoiding hospital admission **+ve**
5. **Patient / service user experience** – patients and families will be supported to remain in a community setting closer to home **+ve**

Estimated diagnosis rate for people with dementia – community teams that support community beds are attuned to the signs and symptoms of dementia and can screen for dementia within community bed settings

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*

- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

This is currently being worked up locally and will be confirmed between now and December 2014.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Supply leads demand- more CIC bed availability results in fewer patients going directly home (mitigation- tighten triaging & referral process for the beds).

Workforce- sufficient nursing/therapies/other staff are available to support the additional beds (mitigation:- LCH already made aware of the potential additional staffing required and the potential need to carry forward their additional winter pressures staffing into 14/15)

- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal. Benefits stated are based on estimate/prediction rather than actuals.
  Ability to specifically attribute savings to these proposals as opposed to savings in systems

  To Other Parts

Savings deriving from a reduction in unplanned acute admissions can only be cashed if overall hospital activity reduces

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Some impact during Q4 of 2014/15, with full implementation and impact from April 2015.

SCHEME NAME :- Increased Community Nursing Capacity to support care at End of Life and enhance 7 day working

SCHEME NO	**15 c**
RESPONSIBLE GROUP	**Effective Discharge and admissions group**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan/Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

This business case seeks funding through the Better Care Fund to enhance and sustain a number of initiatives aimed at supporting the overall transformation of adult health and social care and local system change at scale and pace. The overall scheme will look to extend and enhance the role of existing neighbourhood teams in a range of ways to improve their focus on streamlining discharge and proactively managing patients in the community. The enhancement and development of a number of services will ensure that services are best placed to respond to 7 day working as it is further developed across the local health and social care system. This scheme will complement the primary care developments in reducing admission, readmission and act as a stronger "pull" in the system to safely discharge people from hospital and support their return home.

The individual proposals as outlined below collectively aim to improve patient experience, enable further change on the ground as part of our overall vision for service integration within the city and ensure the system works more effectively to meet demand.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The city of Leeds has embarked on an ambitious and challenging programme of transformational change relating to its provision of adult health and social care. The programme of change centres on responding to increasing demand, managing the needs of an ageing population often with one or more long term condition, operating in a climate of reduced resources and responding to what the people of Leeds say about their experience of services to date. Using the Sir John Oldham model of long term condition management an extensive process of consultation and engagement

took place across the city to agree and sign off the vision for change. Referred to as the Target Operating Model or TOM, the vision aims to respond to the challenges previously outlined and simplify the model of provision. In essence the TOM identifies a number of components which if successfully delivered would join up and enhance health and social care service provision within Leeds. These are:

- Provision of a single gateway or front door to improve access to services across health and social care
- Having in place a service that can effectively respond to people in crisis to make safe, maintain in their home with a package of health and social care focused on maximising independence through rehabilitation and reablement. Within our vision this is referred to as the rapid response service
- Working in a joined up way at the neighbourhood level centred on a registered GP practice population. Having the necessary skills within the team to respond effectively to the needs of the population in a proactive way that promotes health and wellbeing and maximises personalisation, choice and self-management supported by the appropriate professionals/agencies. Within this model the ability to provide case management to patients who require it is key as is working with other agencies both statutory and non-statutory within the neighbourhood
- Having an overall ethos/approach that is centred upon maximising people's independence through a model of goal centred intervention that recognises the significant asset the patient/service user bring to the delivery of the plan of care and its success. Equally the approach will focus on maximising independence through enablement focused on keeping the individual in their own home/community wherever possible/appropriate

Significant progress has been delivered over the last 2 years in terms of achievement of the overall vision for integrated services. This has involved considerable clinical engagement to lead, shape and develop the detail of the model to be delivered at the neighbourhood level.

This financial year is seen as a key period in terms of successful delivery of the remaining elements of our agreed vision, supported with an ongoing programme of development to ensure sustainability and delivery of success.

The opportunity to secure additional funding through the Better Care Fund is seen as a significant enabler in terms of adding to plans already in place or about to roll out with the additional money through BCF allowing these plans to go further and thereby have a move significant impact for both patients and the system.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This proposal is to increase the capacity in the community nursing service at a neighbourhood level (with a specific focus on district nursing services) supporting improved care for End Of Life (EOL) patients and 7 day working.

The service model for this proposal is to deliver the additional capacity to support the above areas within the developing Integrated Neighbourhood Teams (INT). Thirteen INTs are under development providing nursing, therapy and social work input at neighbourhood level, wrapped around GP practices. The additional posts will join the INTs and be managed within the INT leadership and management structure, ensuring that the additional capacity has maximum impact on patient care.

For indicative purposes the proposed funding will support additional posts as follows:

- 2.4 wte x administrators
- 23.5 wte community nurses

The exact staffing structure will be finalised as part of ongoing work to develop integrated neighbourhood teams. Commissioners will be updated with the final staffing structure once agreed.

We intend that this capacity will be in place by the beginning of Quarter 3 2014/15.

All of the key stakeholders will be required to work in an integrated and collaborative way centred on the patient and their personalised care plan, in particular improving coordination of care for patients approaching end of life. The effective and consistent use of EPaCCS and implementation of the Leeds Care Record is critical to this.

Neighbourhood teams are in the process of being established - this is part of the neighbourhood team offer and will be delivered as part of the Integrated Neighbourhood team.

Acute hospital services – particularly in relation to the interface functions e.g. discharge planning

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This proposal will expand capacity in integrated neighbourhood teams in order to work with primary care to:

- proactively manage people to live independently at home, reducing admissions and readmissions
- improve flow from acute settings to reduce length of stay and delayed

transfers of care
- improve performance in meeting people's health needs as they approach the end of life

The increase in community nursing capacity will improve 7 day working and flow.

The End of Life Health Needs Assessment (HNA) recognised the need to increase District Nursing capacity to deliver all aspects of end of life care currently and as the numbers of people approaching end of life and choosing to be cared for and die in their usual place of residence increases.

To date there has been a reduction in the number of people dying in hospital nationally and in Leeds. Leeds ONS data referred to in the HNA shows a decrease in hospital deaths from 50.2% in 2007 to 48% in 2011. Deaths at home have increased from 19% to 21% over the same period and increasing capacity within neighbourhood teams should enable this figure to continue rising.

This increased capacity will also enable the service to better support the earlier discharge of all patients and prevent admissions through proactive management.

This will contribute overall to reducing acute activity and costs within the system.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£500k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Patient satisfaction measures to be developed in line with the city wide work plan for End of Life care
- Improved adherence to Service Delivery Framework for End of Life Care, including bereavement support
- Increase the numbers of Independent Nurse Prescribers within neighbourhood teams actively prescribing for patients approaching end of life.
- Increase the number of nurses who can verify expected death within neighbourhood teams.
- Maintain current PPD target for an increasing number of End of Life Care patients cared for in usual place of residence
- On going review of citywide EoLC data collated by the CCGs from 2014/15 Q1 in line with HNA recommendations

During Q2 2014/15 LCH will develop key metrics and baselines for the above indicators as the service model develops, in conjunction with commissioners. The Adult Business Unit Business manager with identified performance management resource will support this work.

- Estimated total additional activity for the additional resource would be c30,000 contacts (FYE), depending on the final service delivery model agreed.
- The proposals will improve other aspects of quality:
    - providing more early support to patients recognised as palliative;
    - potentially improving symptom control by increasing the numbers of Independent Nurse Prescribers actively prescribing for patients approaching end of life;
    - reducing the need for GP visits in and out of hours through this increased prescribing and more nurses being trained to verify expected death.

For illustrative purposes
The range of possible contacts is:

Minimum - 22,500 (based on x 1 daily contact for 1 month at intermediate stage and x 2 daily contacts for 1 week at intensive stage).
Maximum - 112,000 (based on x 1 daily contact for 3 months at intermediate stage and x 3 daily contacts for 2 weeks at intensive stage).
and obviously a whole range in between! There are a whole load of variables within that range.
This is based on an assumption of 500 patients a year.

Based on the investment proposed and using current average number of contacts per WTE based on the current contract for DN -24 services.
The proposed investment buys 23.5 WTE clinical staff (based on B5). we know that in reality we are likely to further skill mix this to provide best overall skill mix in developing Integrated Neighbourhood Teams. Working on assumption of 23.5 WTE the revised proposed total increase in F2F contacts would be in the region of 35-40,000.
For illustrative purposes this could be broken down as follows:

1 month x1 contact daily (15,500 contacts) +2 weeks x 2 daily contact (14,000 contacts) + 4 days x 3 daily contacts (6,000 contacts) = 35,500 contacts
If additional contacts were required (nearer the 50,000 level), additional investment would be required accordingly to increase the WTE capacity available.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can*

be achieved? - *An outline of a stepped approach to implementation which draws on* *I) learning from either local evaluation or other areas where this has been implemented, and* *ii) engagement with partners about the deliverability of the proposal*
• Strong partnership working between LCH and LTHT • Skilled staff with comprehensive knowledge of community services available
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
• A lot of change is being undertaken at the same time within community nursing and the neighbourhood teams - interdependencies with this work. • Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts. This is being mitigated by increased recruitment resources and staff being recruited on a permanent contracts (risk to be shared with commissioners). • The benefits stated are based on estimate/prediction rather than actual. • An increase in the numbers of patients approaching end of life being supported by integrated neighbourhood teams is dependent on earlier identification and referral of patients by other services • Ability to specifically attribute savings to these proposals as opposed to savings in system per se
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
The scheme will be implemented by April 2015

SCHEME NAME :- Homeless Accommodation Leeds Pathway (HALP)	
SCHEME NO	**15 d**
RESPONSIBLE GROUP	**Diane Boyne**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan / Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Beneficiaries of this project will be men or women, age 16 and over who are in hospital and are homeless. This includes those who are in hostels, sofa surfing, rough sleeping or otherwise insecurely housed. The designated intermediate care beds at St George's Crypt are for those discharged from hospital with ongoing physical health concerns and who would otherwise be rough sleeping. The beds also enable appropriate discharge from hospital for those who would otherwise be unfit for discharge due to their housing status.

There will be a dedicated referral system in to the Homeless Accommodation Leeds Pathway available 24 hours 7 days a week

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The project will:

- Provide 3 single bedrooms designated specifically to this project.
- Look after the health and care needs of each person in the intermediate care bed including food and clothing where necessary. The specialist GP and Nurse will provide health services to the patients in three intermediate care beds at the Crypt.
- Provide daily (Monday-Friday) specialist GP and nursing support in hospital to homeless patients in Leeds General Infirmary and St James' hospitals. Assessment on the wards will enable appropriate care and discharge into the intermediate care beds at the Crypt.
- Provide ongoing case management from specialist homeless Support Workers from the point of referral for homeless people in hospital, working with housing and other services to ensure appropriate accommodation and support is accessed following discharge. The Support Workers will work with people once in the community to avoid readmissions to hospital.
- Actively work with the individuals in the Crypt beds to ensure a maximum stay of three weeks and liaise with other agencies to source appropriate accommodation for them to move in to.
- Provide a detailed needs assessment for the individual upon leaving the intermediate

care beds at the Crypt to aid continuity of care.

The project aims to**:**

- improve the quality of inpatient stay and discharge for homeless people
- coordinate integrated care following hospital discharge preventing readmission to hospital
- improve access to health services in order to reduce morbidity and mortality in homeless people
- improve quality of life for homeless people

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

3rd sector provider and understanding pathway for these patients from acute Trust.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

- Annual cost of inpatient hospital care for homeless patients is 8x that of housed population aged 16-64.[1]
- Homeless people attend A+E 5x as often as housed population, are admitted 3.2x as often and stay 3x as long[2].
- In Leeds in 2013 254 homeless patients had 1652 bed-days in hospital at a cost of £724,020.
- There were 206 readmissions of homeless people within 30 days of discharge.
- This large expenditure does not equate to improved quality or outcomes – the average age of death of homeless people is 47 yrs and associated with the reduced quality of life caused by multi-morbidity[3]

[1] Office of the Chief Analyst. Healthcare for single homeless people. Department of Health, 2010. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250

[2] *Ibid*

The original pathway in London (on which this model is based) demonstrated the following outcomes;

- Homeless patients felt more cared for, and hospital and community staff, through better support, provided better integrated care.
- The strategy resulted in a total reduction of 1000 bed days (30% reduction) in the first full year of service delivery and commensurate cost savings[4]

Timely response	**Assessed within 2 working days (unless self discharged)**	**80%**	**Audit of referral and assessment records**	**monthly**
Reduction in prolonged hospital stay once well	**Reduction in total bed days for homeless people**	**30%**	**Audit of hospital admission data**	**monthly**
Homeless people staying well for longer once discharged	**Reduction in readmissions**	**20%**	**Audit of hospital admission data**	**monthly**
Improved access to specialist primary care	**Registration at York St**	**70%**	**Records audit**	**monthly**
Patients have an integrated care plan	**Patient has a Care plan**	**100%**	**MDT meeting minutes**	**monthly**

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

	St Georges Crypt	Partner	Total
Employee Costs			
24/7 support for 3 rooms over project duration	£70,488		£70,488

[3] Crisis 2011. Homelessness: a silent killer. London Dec 2011. http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf

[4] Hewett, N *et al.* 'Quality Improvement report: A general practitioner and nurse led approach to improving hospital care for homeless people' *BMJ* 2012;345:e5999

GP Costs		£49,735	£49,735
Nurse		£36,693	£36,693
Support Worker x 2		£50,353	£50,353
Staff Training	£1,200		£1,200
Sickness and holiday cover for staff absence	£4,800		£4,800
Total Costs for the duration (10 Months)	**£76,488**	**£136,781**	**£213,269**
Costs (Travel, Emergency consumables)			
Travel costs (residents to appointments)	**£480**		**£480**
Travel costs staff		**£500**	**£500**
Drugs, Dressings		**£1,500**	**£1,500**
Running Costs			
IT Support	**£600**		**£600**
Stationary	**£240**		**£240**
Utilities	**£360**	**£800**	**£1,160**
Consumables e.g. washing powder, laundry	**£240**		**£240**
Clinical Waste disposal	**£960**		**£960**
Corporate overheads		**£20,937**	**£20,937**
Total revenue cost	**£79,368**	**£160,518**	**£239,886**

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Hospital staff identify homelessness and make timely referral to HALP
- York St Practice to accommodate increased number in new registrations and rapid response to ensure smooth transition from hospital
- Increase in referrals to Housing Options as homeless people are identified and signposted

On Activity,

- To ensure those leaving hospital have access to primary care
- Ensuring that homeless people are not discharged to the streets but to emergency or permanent accommodation
- To identify and anticipate the specific needs of homeless people during their hospital admission and discharge and plan accordingly for their care
- To allow earlier discharge for some homeless people by provision of respite beds with intensive primary care and social support
- Increased contact between specialist homeless practice and the most vulnerable homeless people
- By case managing homeless patients on discharge from hospital there is an expectation that re-admissions to hospital for this cohort will be reduced. Assuming a 20% reduction in re-admissions, this equates to 41 avoided admissions per year.
- In Leeds around 50 bed days are lost in hospital each month due to DToC associated with housing issues. Whilst not all of these cases will involve homeless people, there is an expectation that by providing step-down beds through the HALP scheme, DToC for the homeless cohort will be significantly reduced, with an estimated saving of 17 bed days per month (a third of all housing-related DToC).

On Cost,

Measurable outcomes:

- A reduction in readmissions of homeless people to hospital- unable to estimate due to complexity of hospital tariff
- A reduction in total bed days for homeless people in hospital - £217K

1652 bed days 30% reduction in hospital length of stay.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in

the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

These are currently being developed.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

To Success ,

- Reliant on hospital staff identifying appropriate referrals
- Relies on the availability of both emergency and permanent accommodation
- Small number of HALP beds

To Other parts of System,
Increased workload for other agencies as need is identified and signposted

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*

- *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
Implementation during 2014/15, continued into 2015/16.

SCHEME NAME :-	Leeds Equipment Service 7 days a week opening

SCHEME NO	**16a**
RESPONSIBLE GROUP	**Effective discharge and admissions**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan/Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Leeds Community Equipment Services (LCES) provides equipment on a loan basis to patients living in Leeds, to allow them to live safely within their own home. The equipment provided ranges from specialist beds, mattresses and hoists to relatively inexpensive walking aids. Without this equipment many people would need to be admitted to hospital as front line services would not be able to provide adequate/ safe care/ treatment.

The provision of loan equipment is also a key component of many discharge packages, allowing patients to return home to be cared for by community services/ family.

LCES is a critical part of the care system, and without equipment many services (acute and community) would not be able to operate, as community services would have to admit patients to hospitals that were full due to them not being able to discharge patients.

In December 2013 the South and East CCG agreed to fund a pilot to enable LCES to open 7 days a week, as part of the "winter pressures" initiatives. This business case is requesting £130k of funding to continue to deliver a seven day a week service, in effect making seven day a week working the norm, in line with other local and national initiatives. The formal review paper detailing the pilot will be produced in March 2014, however this paper uses the early results of the pilot as the basis of business case.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The pilot has allowed LCES to open from 8.00am to 4.00pm on a Saturday and Sunday, with an emphasis on providing urgent equipment to facilitate early patient discharge or to reduce the need for patients to be admitted to hospital. The pilot started slightly later than planned (22/12/13) and the Saturday/ Sunday service has been provided as scheduled every weekend since.

The pilot is due to end at the end of March 14, unless commissioners agree to fund the seven day a week service on a permanent basis beyond that date.

The business case is requesting an additional £130K of funding, mainly for staffing resources (see Appendix 1).

The seven day a week service will look very similar to the current pilot, with the Store being open 8 till 4 and both a fitter team and an additional driver delivering and collecting essential equipment during this time. Referrals will be taken during opening hours, but only urgent equipment will be delivered/ collected on a weekend, with non urgent requests waiting until the following Monday. As the store will be open, staff, patients and carers can visit the store during a weekend to pick up or drop off equipment or to discuss any general issues/ problems.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The LCES were funded to provide a 7 day service through winter. Following positive feedback from the Acute Trusts and the Community Services, as well as patients, there is a need to maintain this level of service which support system flow.

The expectation is that there will be no break in the 7 day service and that it will continue throughout 2014/15 during which time we will continue to evaluate the impact on admission avoidance and hospital discharge.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The original pilot was established to enable LCES to continue operation across the winter months, increasing capacity to meet the flex of the LTHT services during the winter period. It was hoped that this would enable LCES to contribute to the prevention/reduction of delayed transfers of care from hospital by being able to deliver necessary equipment following the relevant clinical assessment to people returning home, and contributing to the reablement programme aimed at reducing reliance on large packages of care. It will also hoped that the pilot would contribute to the reduction of people requiring permanent care following hospital admission by the provision of appropriate equipment

The benefits for this were thought to be:

- To meet the increased demand on the service through the winter months.
- To ensure that patients receive equipment to enable them to be treated in their own homes and avoid the need for admission to hospital.
- To continue to support hospital discharge by providing requested equipment
- Test the demand, costs and practicalities for a 7 day a week LCES service

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£130k in both 2014/15 and 2015/16

Additional weekly pay costs

No	Staff Group	Sat	Sun	Cost – including on costs and enhancements
2	Cleaners – Band 2	7.5	7.5	
1	Admin – Band 2	7.5	7.5	
1	Storekeeper – Band 3	7.5	7.5	
1	Driver – Band 2	7.5	7.5	
1	Fitter – Band 5	7.5	7.5	
1	Fitter – Band 4	7.5	7.5	
1	Manager – Band 5-7	7.5	7.5	
			Total	£130K

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about*

future outcomes?

Activity

Although the seven day a week service has only been running for a month, it is clear that the system has been welcomed by hospital and community services. The details of the deliveries, fittings and collections are detailed in Appendix 2.

The initial figures show that between 25 and 36 patients are being helped each day. These are all urgent cases, and most of them could have had to go into hospital. There were also a small number of weekend discharges that LCES helped by providing essential equipment.

There has also been an additional 29 pieces of equipment collected directly from stores – up to 8 collections per day.

Yearly comparison of activity

2012/13				
Month	**Total Issues**		**Total collections**	
Dec-12	**6176**		**3636**	
Jan-13	**6471**		**5224**	
Feb-13	**6936**		**5519**	
Mar-13	**6588**		**4380**	
2013/14				
Month	**Total Issues**	**Difference**	**Total collections**	**Difference**
Dec-13	**7357**	**1181 increase**	**4698**	**1062 increase**
Jan-14	**7050**	**579 increase**	**6042**	**818 increase**
Feb-14				
Mar-14				

Yearly Comparison of Key Performance Indicators

2012/13			2013/14		
Month	% Delivered within 7 working days		**Month**	% Delivered within 7 working days	
Nov-12	97.74%		**Nov-13**	96.89	-0.85

Dec-12	98.29%		**Dec-13**	99.13	+0.84
Jan-13	97.77%		**Jan-14**	99.35	+1.58
Feb-13	92.78%		**Feb-14**	99.63	+6.85
Mar-13	95.03%		**Mar-14**		

Benefits

The original benefits of the pilot related to:
Winter pressures demand – LCES has managed all of the demand from the "winter pressures" period, and has not had to turn down any request for urgent delivery/ collection.

Admission avoidance – Ability to deliver equipment to people at home will improve the quality of care and also reduce the need for unnecessary admission. This is particularly the case for people at end of life and frail older people.

Early discharge – fewer people will be delayed in hospital as the equipment required to deliver care will be delivered Saturday and Sunday (7 days service). This will reduce the risk of hospital acquired infections etc. as well as releasing beds

Lessons learnt – LCES has learnt a lot during the pilot, and the following changes will be implemented if this proposal is accepted:

- New shifts - All relevant staff will be on a rota to work weekends. This will provide a more robust way of covering the weekend shifts.
- Management support – It is important that staff working on weekends are supported if anything unexpected happens. This proposal includes a manager working each weekend.

In addition to the above, the following benefits have been seen during the pilot:

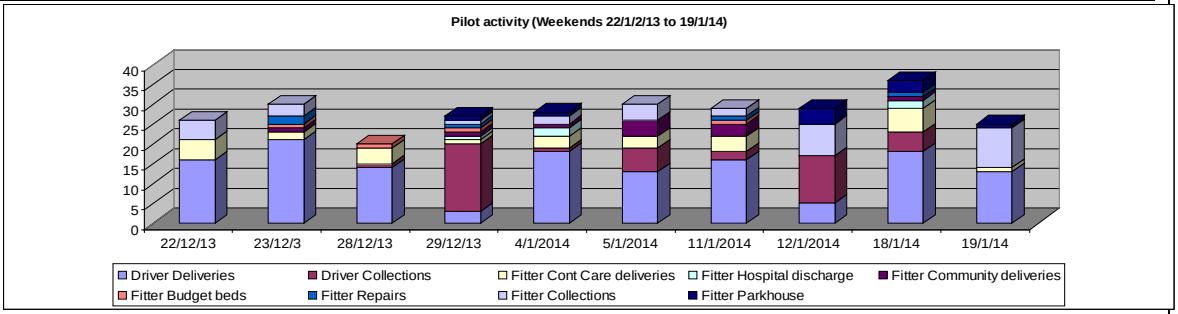
- Emergency repairs of critical equipment can now be picked up by LCES instead of expensive external contractors
- Peripheral equipment stores that were set up for clinical staff to access equipment on a weekend can be reduced. This saves clinical staff having to deliver equipment.
- The service is able to collect more equipment, especially on a weekend when carers or more likely to be available.
- The peaks and troughs of the scheduled work have been smoothed out, in particular the normal Monday morning rush to catch up with urgent deliveries has been eliminated.

A more detailed review of the pilot will be produced in March 2014, giving a more detailed picture of the benefits.

Appendix 2 – LCES weekend activity

		22/12/13	**23/12/3**	**28/12/13**	**29/12/13**	**4/1/2014**	**5/1/2014**	**11/1/2014**	**12/1/2014**	**18/1/14**	**19/1/14**
Drive	**Deliveries**	16	21	14	3	18	13	16	5	18	13

r	**Collections**			1	17	1	6	2	12	5	
Fitter	**Cont Care deliveries**	5	2	4	1	3	3	4		6	1
	Hospital discharge				1	2				2	
	Community deliveries		1		1	1	4	3		1	
	Budget beds		1	1	1			1			
	Repairs		2		1			1		1	
	Collections	5	3		1	2	4	2	8		10
	Parkhouse				1	1			4	3	1
	Total	**26**	**30**	**20**	**27**	**28**	**30**	**29**	**29**	**36**	**25**



FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is

affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- Strong partnership working between LCH and LTHT
- Skilled staff with comprehensive knowledge of community services available

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Will be managed by the effective admissions and discharge group.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

A pilot of these scheme has already started to run this year and will expand and roll over into next year.

SCHEME NAME :- **Extended Hours for EDAT**	
SCHEME NO	**16b**
RESPONSIBLE GROUP	Adult Integrated Care Programme
ACCOUNTABLE LEAD OFFICER	Diane Boyne**/**Paul Morrin/ Sam Prince/ ASC tbc (Michelle Tynan or Dennis Holmes)
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Extend hours for the Early Discharge Assessment Team (EDAT) based within A&E and assessment floor at St James's Hospital, including 7 day working

The proposal is to enhance the EDAT service that operated successfully over the winter period, including 7 day working, and respond to the outcomes of a recent commissioner-led service review (attached at Appendix 1).

The EDAT service enables patients to be diverted to appropriate community alternatives, reducing admissions and enabling proactive responses to patient's needs, returning patients to a community setting as soon as possible.

The operational hours are currently Monday to Friday 8am – 6pm and weekends 8am – 4pm and staffing is provided in a partnership model with contributions from LTHT, LCH and ASC. Discharge Planning is provided by EDAT to patients in ED, historically approximately 21% of these were discharged within 4 hours, however with the enhanced winter resource this increased to 55%. The remaining 45% were then discharged promptly from CDU and the Acute Floor.

The funding would cover staffing costs within LCH, LTHT and ASC. LCH would act as the lead provider with responsibility for service coordination and delivery against a revised service specification, which is currently under development.

Specifically the funding will support a revised service that will:

- Function 7 days per week covering 0800-2000.
- Focus on patients in the following categories;
    - No admission
    - 0 day admission
    - 1 day admission (overnight)
- Support transfer of care to existing services following these timescales
- Develop KPIs – quantitative and qualitative - to enhance current reporting and demonstrate service impact. This will be supported by identified resource within the LCH performance team and supported by the Adult Business Unit Business Manager.
- Employ a range of additional staff to support the extended opening hours and service focus on 0-1 days. Additional staffing roles will include care management, direct intervention and support functions across the following disciplines:
    - administration

- social work
- therapy
- nursing capacity

- Consideration will be given to skill mix with the introduction of additional non-registered therapist roles and to deployment of resource over the 7 day, 8-20h period to ensure that resources are aligned to demand patterns.
- The additional funding will be delivered within the existing team leadership structure. The team will be managed by the existing B7 Team Manager to ensure delivery against agreed targets and performance indicators. The team manager reports to the Service Manager within LCH and is also supported by a clinical Pathway Lead within LCH.
- Administrative support for the team will enable effective use of clinical time and support communication with patients, families and other departments and collection of relevant data.
- The existing staffing structure is provided at appendix 1 within the review. The additional funding will supplement this structure.
- For indicative purposes the proposed funding will support additional posts, to include the disciplines outlined above, as follows:
  - 1 x administrator,
  - 1 x senior OT,
  - 1 x senior physio,
  - 1 x senior Nurse,
  - 1.5 x senior social worker/joint care manager,
  - 1 x therapy assistant.
- The exact staffing structure will be finalised in discussion between LCH, LTHT, and Adult Social Care to enable effective delivery of the service model outlined above. Commissioners will be updated with the final staffing structure.
- A service specification, reflecting the above proposal has been drafted and will be agreed between LCH and commissioners subject to support for this proposal.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

As identified at the whole system discharge workshop in January 2014, increased capacity to bridge from hospital to community settings will enable more effective joint discharge planning to reduce length of stay and readmission risk. The proposal also responds to the outcomes of the Service Review and experience during winter 2013/14.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

All of the key stakeholders will be required to work in an integrated and collaborative way to support delivery of the proposed enhanced service.

This is part of the wider development of integrated neighbourhood health and social care teams and secondary care services.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£300k recurrently in both 2014/15 and 2015/16

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The additional winter resource has enabled the service to increase staffing capacity to provide a 7 day service. On average EDAT have discharged 55% of patients that they were involved in planning a discharge from ED within 4 hours (approx 68 patients a month). The remainder were discharged soon after from CDU or the Acute floor depending on where they were admitted to. Last year, prior to additional resource, EDAT discharged 21% of the patients seen in ED. It is anticipated that EDAT would be able to sustain these levels once the additional resource identified has been secured.

As noted in the EDAT review, further work is required to develop effective measurement of impact of EDAT. This work will be led by the EDAT team manager, supported by dedicated performance resource, as part of the implmeentaiton of the enhanced service..

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The following performance measures have been proposed. The lead provider will work with other providers to ensure provision of the required information. As a number of measures are new or developmental, performance management resource will be secured to support development and delivery against the KPI schedule. The lead provider will work with providers and commissioners to confirm the KPIs and develop mutually agreeable indicators, baseline position and thresholds during Q2. It is anticipated that some indicators will be measured at service level, whilst others will be addressed at system level.

Proposed indicators

Performance Indicator	*Indicator*	*Threshold*	*Frequency of Monitoring*
Quality/Outcomes			
Patients are discharged safely to an appropriate community setting	% of patients re-admitted within 30 days		Quarterly
Performance/Productivity			
Patients selected for admission avoidance pathways are discharged from ED within 4 hours	% of patients	95%	Quarterly
Patients selected for EDAT admission avoidance pathways are discharged within 24 hours	% of patients	100%	Quarterly
Number and % of patients screened by source within agreed timescale: • ED • PCAL • CDU			Quarterly
Number and % of patients identified for admission avoidance pathway by source: • ED • PCAL			Quarterly

• CDU			
Number of patients discharged by source within agreed timescales: • From ED • Via PCAL • From CDU			Quarterly
Destination on discharge (by source): • Home no extra support • Home with reablement • Home with an initial package • Home with increased support • Home with ICT • CIC bed • CICU • Emergency respite care • Other			Quarterly
Number of patients identified for admission avoidance but no capacity by source (reason for delay): • From ED • Via PCAL • From CDU • From Acute Floor – by ward			Quarterly
Qualitative data/information - to be developed			Quarterly
Non-availability of service with reasons, including staffing	Number of occasions		

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- The EDAT service is interdependent on a number of other services across the system for maximum effectiveness e.g. community beds, availability of reablement, home care, geriatrician input in ED. Some of these areas are covered in other BCF submissions or in resilience planning currently underway.
- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts/backfill.
- There is a risk that some GP practices will not 'buy in' to the model and may be resistant to adopting it.

- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal.
- The benefits stated are based on estimate/prediction rather than actual.
- The ability to track patients through the system. This will be mitigated by the use of CareTrak reports.
- Ability to specifically attribute savings to these proposals as opposed to savings in system per se.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Scheme to commence in 2014/15 and continue on in 2015/16

SCHEME NAME :- Enhancing Integrated Neighbourhood Teams (Discharge Facilitators)	
SCHEME NO	**16 c**
RESPONSIBLE GROUP	**LTC, Dementia, EOL, Frail Elderly Programme, Diane Boyne**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	**Emma Fraser**
VERSION & DATE	**V0.3 12/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

This business case seeks funding through the Better Care Fund to enhance and sustain a number of initiatives aimed at supporting the overall transformation of adult health and social care and local system change at scale and pace. The overall scheme will look to extend and enhance the role of existing neighbourhood teams in a range of ways to improve their focus on streamlining discharge and proactively managing patients in the community. The enhancement and development of a number of services will ensure that services are best placed to respond to 7 day working as it is further developed across the local health and social care system. This scheme will complement the primary care developments in reducing admission, readmission and act as a stronger "pull" in the system to safely discharge people from hospital and support their return home.

The individual proposals as outlined below collectively aim to improve patient experience, enable further change on the ground as part of our overall vision for service integration within the city and ensure the system works more effectively to meet demand.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The city of Leeds has embarked on an ambitious and challenging programme of transformational change relating to its provision of adult health and social care. The programme of change centres on responding to increasing demand, managing the needs of an ageing population often with one or more long term condition, operating in a climate of reduced resources and responding to what the people of Leeds say about their experience of services to date. Using the Sir John Oldham model of long term condition management an extensive process of consultation and engagement took place across the city to agree and sign off the vision for change. Referred to as the Target Operating Model or TOM, the vision aims to respond to the challenges

previously outlined and simplify the model of provision. In essence the TOM identifies a number of components which if successfully delivered would join up and enhance health and social care service provision within Leeds. These are:

- Provision of a single gateway or front door to improve access to services across health and social care
- Having in place a service that can effectively respond to people in crisis to make safe, maintain in their home with a package of health and social care focused on maximising independence through rehabilitation and reablement. Within our vision this is referred to as the rapid response service
- Working in a joined up way at the neighbourhood level centred on a registered GP practice population. Having the necessary skills within the team to respond effectively to the needs of the population in a proactive way that promotes health and wellbeing and maximises personalisation, choice and self-management supported by the appropriate professionals/agencies. Within this model the ability to provide case management to patients who require it is key as is working with other agencies both statutory and non-statutory within the neighbourhood
- Having an overall ethos/approach that is centred upon maximising people's independence through a model of goal centred intervention that recognises the significant asset the patient/service user bring to the delivery of the plan of care and its success. Equally the approach will focus on maximising independence through enablement focused on keeping the individual in their own home/community wherever possible/appropriate

Significant progress has been delivered over the last 2 years in terms of achievement of the overall vision for integrated services. This has involved considerable clinical engagement to lead, shape and develop the detail of the model to be delivered at the neighbourhood level.

This financial year is seen as a key period in terms of successful delivery of the remaining elements of our agreed vision, supported with an ongoing programme of development to ensure sustainability and delivery of success.

The opportunity to secure additional funding through the Better Care Fund is seen as a significant enabler in terms of adding to plans already in place or about to roll out with the additional money through BCF allowing these plans to go further and thereby have a move significant impact for both patients and the system.

The Discharge Facilitator roles provide a link between hospital and community services ensuring smooth transfer of care. Through active case management of patients using clinical skills and extensive working knowledge of community services, Discharge Facilitators support patients who are ready to be discharged. This direct link and strong communication with wards ensures timely discharge of patients.

The proposal is to increase the number of discharge facilitators to 5 WTE, to focus on end of life (EoL) patients and those leaving medicine/elderly wards. This proposal builds on the positive outcomes to date from existing 2 WTE EoL discharge facilitator roles, and the service for medicine/elderly wards that was put in place over winter 2013/14.

The existing EoL discharge facilitators have demonstrated clear improvements in the quality of discharge planning for end of life care, ensuring a clear link between the district nursing teams and the wards where the patient is being discharged from. The 2 WTE additional discharge facilitators put in place over the winter targeted the

pressured areas supporting patient flow across the system and helping the system to respond when in crisis. They have also focussed on developing operational ways of working with LTHT staff and received positive feedback across the system based on their impact on improving flows and managing effective discharge.

Additional staff to support the extended opening hours and expanded coverage will be recruited. The current planning assumption is that we will increase discharge facilitators by 5.2 WTE. (currently have 2 WTE EoL discharge facilitators permanently in post.) The bid is based on indicative costings for 1 B7 clinical team leader, 2 WTE B6 equivalent (nurse/therapist/Social worker), 2 WTE B5 equivalent, 0.2 B3 admin, plus associated oncosts for weekend working/overheads.

The proposal will provide additional capacity which will enable the service to

- provide increased coverage
- provide a service over 7 days 08:30-16:30.
- Focus on patients in the following categories:
    - Medicine/elderly wards
    - End Of Life
- Support transfer of care to community services in accordance with patient's personalised care plan
- Develop KPIs – quantitative and qualitative - to enhance current reporting and demonstrate service impact. This will be supported by identified performance resource within LCH

The service delivery model will be amended to integrate all the discharge facilitators (currently separate functions covering EOL and Medicine & Elderly) into one discharge facilitation team over the next few months to provide an effective 7 day service with associated leadership and admin support to provide a service across EoL and medical/elderly patients. As part of this bringing together there may be some further amendments to skill mix/staffing and we will keep you updated once a final staffing structure is agreed for the new team.

The LCH Discharge Facilitator Team (covering EoL and Medicine/Elderly wards) will work with LTHT's discharge team (which provides support across LTHT) and with the Early Discharge Assessment Team (EDAT) (which focuses on 0-1 days) to ensure coordinated processes.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Commissioning - LSE CGG
Provider -LCH

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

- The enhanced discharge facilitator team will improve flow from acute settings to reduce length of stay and delayed transfers of care and builds on the successful model in place. This will contribute overall to reducing acute activity and costs within the system.
- As identified at the 'whole system discharge' workshop in January 2014, increased capacity to bridge the gap between hospital and community settings will enable more effective joint discharge planning to reduce length of stay and readmission risk.
- Improve the quality of the discharge through a reduction in discharge related incidents
- Improve the patient's experience of their discharge/facilitate Preferred Place of Care(PPC)/Preferred Place of Death (PPD) at End of Life
- Improve the efficiency of the integrated neighbourhood teams by reducing the amount of time taken post discharge which is currently spent dealing with issues.

The key metrics to be used to monitor the impact of this scheme are;

- Number of discharges facilitated
- Time from referral to discharge.
- Number of discharge planning meetings attended / month.
- Number of discharge related incidents
- Patient satisfaction/patients achieving PPC/PPD

- Length of stay / delayed transfers of care – system measures

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£260k FYE (clinical resources)

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

All of the key stakeholders will be required to work in an integrated and collaborative way to support delivery of the proposed enhanced service. The key stakeholders are Leeds Community Healthcare Trust (LCH) as the provider and Leeds Teaching Hospital Trust (LTHT) – a strong interface is essential for the success of this scheme.This scheme is part of the wider development of integrated neighbourhood health and social care teams and secondary care services.

Activity (what reductions in relevant activity will the proposal have expressed as numbers of people/% of current activity levels?)

There will be an increase in the number of people managed through this service. An indicative number of referrals for the revised service per annum would be a 150% increase in referral and activity levels. Historical data for this service is limited and as outlined above, further work is required to develop effective measurement of the impact of the redesigned Discharge Facilitator Team. This work will be led by the service team, supported by dedicated performance resource from LCH, as part of the implementation of this enhanced service providing an improved baseline, performance indicators and thresholds for future performance management.

Cost

As described in the introduction this proposal will positively impact on patient flow and overall system performance. Work is being undertaken to determine the planned cost impact at a whole system level.

The scheme proposes creating new discharge facilitation roles that will work with elderly patients to ensure timely discharge. The existing service will be scaled up by 5.2 WTE to work with the existing teams to reduce excess bed days on general medicine by 50%.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*

- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- Strong partnership working between LCH and LTHT
- Skilled staff with comprehensive knowledge of community services available

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- The success of the discharge facilitators is dependent on ongoing strong partnership working with staff at Leeds Teaching Hospitals Trust
- Ability to specifically attribute savings to these proposals as opposed to savings in the system per se.

Total impact of all proposed changes is not fully modelled or known at this time,

though work is underway. (Whole system risk).
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
The scheme will be implemented by Q3 2014/15

SCHEME NAME :- **Enhancing Integrated Neighbourhood Teams**	
SCHEME NO	**16d & 16g**
RESPONSIBLE GROUP	Adult Integrated Care Programme
ACCOUNTABLE LEAD OFFICER	Diane Boyne**/**Paul Morrin/ Sam Prince/ ASC tbc (Michelle Tynan or Dennis Holmes)
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

This scheme will look to extend and enhance the role of existing neighbourhood teams in a range of ways to improve their focus on streamlining discharge and proactively manage patients in the community.

More specifically this will include:

d) Extend the home care service to support 24/7 support for service users.
Extend the home care service capacity to enable more people to be cared for in their own home 7 days a week and provide new packages of care at weekends and late evenings.

g) Retain interface geriatrician role
The proposal is to maintain the existing interface geriatrician support as part of integrated neighbourhood teams, which enables effective clinician to clinician liaison to maintain patients at home and proactively manage patients to prevent avoidable admissions. This will be delivered as an integrated service alongside other community geriatrician input.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The proposals outlined above will expand capacity in integrated neighbourhood teams to work with primary acre to:

- proactively manage people to live independently for longer at home, reducing admissions and readmissions and
- improve flow from acute settings to reduce length of stay and delayed transfers of care

Overall this will contribute to reducing acute activity and costs.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Leeds community Healthcare and Leeds Teaching Hospitals NHS Trust

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Quantitative measures will include measuring changes in:

- hospital activity (Inpatient, Outpatient and A&E)
- primary care activity
- community services activity (health and social care)
- Pharmacy costs
- Delayed transfers of care
- Readmission rates

Qualitative measures will include

- EQ5D
- Goal Attainment tools
- Patient Stories and satisfaction tools

In addition specific metrics can be developed for each proposal e.g. LCES KPIs.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

Costs for scheme 16d are still be calculated. Initial calculations indicate that £750k will be required.

Costs for scheme 16g are £200k recurrently for both years.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Extending access to home care packages into the evening and over weekends is anticipated to facilitate earlier discharge of patients, helping reduce DToC. Currently DToC due to delays associated with accessing home care packages accounts for around 125 lost bed days per month. Whilst this additional capacity is unlikely to eliminate these delays, we expect the extra capacity to reduce delays by 20% for this cohort.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an “Outcomes Based Accountability” (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an

individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Currently being worked up between now and December 2014.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts/backfill.
- There is a risk that some GP practices will not 'buy in' to the model and may be resistant to adopting it.
- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal. Benefits stated are based on estimate/prediction rather than actuals.
- Ability to specifically attribute savings to these proposals as opposed to savings in systems.

whole system risk. Total impact of all proposed changes is not fully modelled or known.
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
For 16d the scheme is likely to start in April 2015. For 16g it has commenced this year and will roll over into 2015/16.

SCHEME NAME :- Enhancing Integrated Neighbourhood Teams (Better me Programme)Discharge	
SCHEME NO	**16e**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	**Diane Boyne**
VERSION & DATE	**V0.3, 12/09/14**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

This business case seeks funding through the Better Care Fund to enhance and sustain a number of initiatives aimed at supporting the overall transformation of adult health and social care and local system change at scale and pace. The overall scheme will look to extend and enhance the role of existing neighbourhood teams in a range of ways to improve their focus on streamlining discharge and proactively managing patients in the community. The enhancement and development of a number of services will ensure that services are best placed to respond to 7 day working as it is further developed across the local health and social care system. This scheme will complement the primary care developments in reducing admission, readmission and act as a stronger "pull" in the system to safely discharge people from hospital and support their return home.

The individual proposals as outlined below collectively aim to improve patient experience enable further change on the ground as part of our overall vision for service integration within the city and ensure the system works more effectively to meet demand.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The city of Leeds has embarked on an ambitious and challenging programme of transformational change relating to its provision of adult health and social care. The programme of change centres on responding to increasing demand, managing the needs of an ageing population often with one or more long term condition, operating in a climate of reduced resources and responding to what the people of Leeds say about their experience of services to date. Using the Sir John Oldham model of long term condition management an extensive process of consultation and engagement took place across the city to agree and sign off the vision for change. Referred to as the Target Operating Model or TOM, the vision aims to respond to the challenges previously outlined and simplify the model of provision. In essence the TOM identifies a number of components which if successfully delivered would join up and enhance health and social care service provision within Leeds. These are:

- Provision of a single gateway or front door to improve access to services across health and social care
- Having in place a service that can effectively respond to people in crisis to make safe,

maintain in their home with a package of health and social care focused on maximising independence through rehabilitation and re-aliment. Within our vision this is referred to as the rapid response service

- Working in a joined up way at the neighbourhood level centred on a registered GP practice population. Having the necessary skills within the team to respond effectively to the needs of the population in a proactive way that promotes health and wellbeing and maximises personalisation, choice and self-management supported by the appropriate professionals/agencies. Within this model the ability to provide case management to patients who require it is key as is working with other agencies both statutory and non-statutory within the neighbourhood
- Having an overall ethos/approach that is centred upon maximising people's independence through a model of goal centred intervention that recognises the significant asset the patient/service user bring to the delivery of the plan of care and its success. Equally the approach will focus on maximising independence through enablement focused on keeping the individual in their own home/community wherever possible/appropriate

Significant progress has been delivered over the last 2 years in terms of achievement of the overall vision for integrated services. This has involved considerable clinical engagement to lead, shape and develop the detail of the model to be delivered at the neighbourhood level.

This financial year is seen as a key period in terms of successful delivery of the remaining elements of our agreed vision, supported with an ongoing programme of development to ensure sustainability and delivery of success.

The opportunity to secure additional funding through the Better Care Fund is seen as a significant enabler in terms of adding to plans already in place or about to roll out with the additional money through BCF allowing these plans to go further and thereby have a move significant impact for both patients and the system.

Context

This proposal aims to complement and build up on existing good practice within the city – e.g. identification of patients at risk, integrated working, supported self-management and by taking evidence from elsewhere in the country and developing a Leeds based model that is clinically led, responsive and effective. The approach outlined aims to empower patients to self-care and manage and reduce ongoing/long term requirement for input from statutory services.

The outlined proposal is informed by early adopter work done locally in 2 practices in the West of the city (process for selection previously agreed with the 3 CCG's). Securing additional funding through this bid would allow for share and spread at scale to maximise impact across the whole system alongside further opportunity to test and refine the model at the local level. Additional resource (clinical staff) would be required to roll out the model further. The impact of the additional investment would be monitored over and above the core service offer to clearly articulate the return on investment made.

The recent changes to the GP contract (Proactive Management) provide a clear link to this proposal which would provide the additional resource required in the system to effectively manage relevant patients identified on practice 2% lists through engagement with the programme.

Programme Delivery

Patients for the programme would be selected through a number of routes e.g. use of the Risk Stratification Tool, MDT discussion, Case Management meeting.

From available evidence the most appropriate patients would be in the lower end of the top 2% and the higher end of the medium risk category. This would then allow for the programme to demonstrate if successful impact on regression to the mean.

- Following initial assessment and patient consent, through discussion with the MDT a goal centred plan of care would be agreed between the patient and relevant professionals
- Based on evidence from elsewhere and here in Leeds the plan would be delivered over an 8-12 week period
- As part of the plan a key worker would oversee delivery which would involve a range of personnel including Health Trainers/Voluntary Sector providers
- Based on goals identified at the conclusion of the programme the aim would be that the patient should have achieved their goals and have the tools, skills and confidence to continue to self-manage on an ongoing basis
- The plan would be to monitor progress/impact over the longer term for each patient successfully exiting the programme
- From available evidence it is clear that the programme is a powerful way of making a difference to things important to the patient and is consequently more sustainable in the long term.

Strategic Fit

This proposal fits with the national and local agenda to improve care for people with long term conditions by taking a much more proactive approach with a focus on patient's identified goals.

The Better Me Programme would be one element of anticipatory care within the city and would link the Year of Care work stream. The initiative also supports the national Pioneer work in enabling the city to go further and faster in terms of impact.

Proof of Concept

A small successful trial with 2 GP practices has just been completed (see Appendix 1 for the full evaluation report). This demonstrates the clear added value of the programme. The GPs involved also evaluated the programme positively for patients.

Scaling up

A process of wider testing is proposed in Quarter 3/4 2014/15 with the programme being rolled out to a further 30 GP practices across the city. The roll out and delivery of this programme will be delivered through the additional resource requested in partnerships within the Neighbourhood Teams. Spread to the remaining practices within the city would be anticipated in Q1/Q2.

The plan would be for two implementation co-ordinators to start in post at the beginning of July 14 to take forward implementation. They will be the link to identified practices and will continue to develop and refine the 'offer' The project team will ensure there is a robust workforce plan to support the timely recruitment of staff and also support development of existing staff where required. Work is underway to ensure the right HR capacity is in place to manage the recruitment process required.

Following the trial evaluation further work is required as part of the next stage of the planning to determine the exact team size and skill mix required. This will be managed against the back drop of

the existing community nursing and therapy services undergoing considerably change as part of the Integration Programme; the delivery of the TOM will result in changes to the existing workforce.

The learning and experience from the wider testing will be then used to refine the model before it is rolled out to the remaining practices from Quarter 1 2015/16.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Commissioner – LSE CGG
Provider – LCH / LCC ASC

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

<u>Evidence of Need and Effectiveness</u>

The evidence of patients identified through the risk management tool is that there is no systematic programme of support and intervention offered to maximise their independence and self-care. The result is that across the city we are not maximising our opportunities to change patient behaviour and subsequent demand for services.

Models similar to the bid outlined have been developed and tested elsewhere in the country and have been shown:

- Improved patient and carer experience and satisfaction
- Improved quality of life and ability to self-care
- Significant contribution to savings across the system

The proposals outlined above will expand capacity in integrated neighbourhood teams to work with primary care to:

- proactively manage people to live independently for longer at home, reducing admissions and readmissions and
- improve flow from acute settings to reduce length of stay and delayed transfers of care

Overall this will contribute to reducing acute activity and costs.

Implementation of Proactive Care models in other areas (e.g. Liverpool, Kent) has demonstrated considerable benefits to patients – especially around the quality of life and ability and confidence to self-care. With regard to the system - reduced hospital admissions, reduced length of stay, reduced use of urgent care and GP/practice nurse appointments and a reduction in avoidable repeat prescriptions.

Historically Leeds has not had in place a systematic model to proactively manage patients identified as being at risk with a view of reducing dependence on statutory services.

This proposal aims to fill this gap by offering a city wide programme to all appropriately identified patients as an addition to the core neighbourhood team service offer.

The programme would aim to focus on patients with long term conditions and be delivered through a coproduced goal centred personal plan of care aimed at increasing personal confidence and ability to self-care/manage.

The programme would offer a further option within the menu of options that GP's and integrated teams can access to manage patients appropriately at the neighbourhood level.

Quantitative measures will include measuring changes in:

- hospital activity (Inpatient, Outpatient and A&E)
- primary care activity
- community services activity (health and social care)
- Pharmacy costs
- Delayed transfers of care
- Readmission rates

Qualitative measures will include

- Goal Attainment tools (GAS, TOM)
- Patient Stories and satisfaction tools

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£1.5m FYE (clinical resources)

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*

- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

All of the key stakeholders will be required to work in an integrated and collaborative way centred on the patient and their personalised care plan.

The neighbourhood teams – notably community nursing, therapy and social work staff, primary care, Health Trainers, specialist services, voluntary sector organisations This is part of the wider development of integrated health and social care teams which requires significant changes in the way that teams are configured and work.

Secondary care services – particularly in relation to interface functions e.g. discharge planning.

Activity Impact

The planned changes in activity are difficult to quantify at this stage. Previous implementation of a proactive care model in Kent showed the following findings based on patients successfully completing the programme. These can be taken as an indicative estimate of the types of results that could be seen in Leeds:

- 15% reduction in A&E attendance,
- 55% reduction in non-elective admissions,
- 37% of cohort had reduced admissions risk,
- EQ5D assessments show 75% of patients reporting improvement in functional quality
- 86% no longer anxious about condition from baseline of 46%
- Current estimate of the number of patients expected to go through the programme in a year is 750-1200

Early results from the small scale trial conducted in Leeds in 2014 showed the trial was successful:

- Ten of the twelve patients completed the programme
- Average **12.6%** increase in reported health (EQ5D)
- Average increase of **14.9** of their Goal Attainment Score.
- Six patients who scored as moderate/high risk of falls at the start of the programme all had **improved** scores at the end of the programme.
- Two patients have had their predicted risk level **reduced** [based on Risk Stratification data as at 3-4 months post-trial]
- Average reduction of **2.4** GP visits [based on Risk Stratification data as at 3-4 months post-trial]

Cost (where and how much cost would you expect to save from this proposal based upon the reductions in activity levels assumed?)

Implementation of a proactive care programme in Kent achieved savings of £1,000 per patient that successfully went through the programme. This figure is one we aim to replicate in Leeds.

Early results from the small scale trial conducted in Leeds in 2014 showed an average reduction of £410 [based on Risk Stratification data as at 3-4 months post-trial] per person for the 3-4mth period.

The activity levels detailed above should translate into cost savings. This will need to be managed across the whole system due to the interdependency of key proposals.

BCF National conditions

- **Plans to be jointly agreed.** The proposals respond to the implementation of the Target Operating Model for integrated adult health and social care services, which has been agreed at the Transformation Board.
- **Protection for social care services.** The proposals include funding for health and social care resource as part of integrated working at neighbourhood level and to support discharge planning
- **7 day services to support discharge and reduce admissions.** Many of the schemes included in the Enhanced Neighbourhood Team proposal specifically increase capacity at weekends and out of hours to support timely discharge and reduce risk of admission.
- **Better data sharing between health and social care based on the NHS number -** The integrated neighbourhood team model is based around a multi-disciplinary team, including both health and social care, working closely together to deliver a programme of care. The NHS Number has been agreed as the common currency between the different organisations. This work is support by on-going developments in information governance and data sharing between health and social care organisations in Leeds, lined to pioneer status and Leeds Care Record.
- **Ensuring a joint approach to assessments and care planning and ensure that where funding is used for integrated care there will be an accountable professional** – integrated neighbourhood teams will have a joint multiagency and multi-professional approach to assessment and care planning, including patient and family engagement in this process. This will be supported by a case management approach, including proactive care, and named leads for patients who are being case managed within the integrated neighbourhood teams.
- **Agreement on the consequential impact of changes in the acute sector.** The proposals outlined are designed to reduce the overall number of acute beds required and reduce length of stay through a more proactive, community based response. The overall impact and management of this will have to be monitored closely between commissioners and providers.

BCF Performance Targets

- **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes** – enhancing neighbourhood teams will enable people to live as independently as possible for as long as possible in their own homes.
- **Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services**. Effective discharge management and enhancing neighbourhood teams will enable people to live as independently as possible for as long as possible in their own homes.
- **Delayed transfers of care from hospital per 100,000 population.** The discharge facilitator capacity will improve flow from acute to community settings reducing DTOC. The increase in community nursing will also support more timely discharge.
- **Avoidable emergency admissions** – Proactive Care will improve patients' ability and confidence to self-manage their condition. Links with 3rd sector and tele-technologies will support this.
- **Patient / service user experience** – Proactive Care will deliver a holistic, patient centric,

personalised programme of care based on patient goals. The use of a multidisciplinary team will enhance the perception of a seamless service. More people will be able to die at home with the increased capacity in community nursing.

Estimated diagnosis rate for people with dementia – Proactive Care may identify patients not currently diagnosed with dementia who are exhibiting early symptoms.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
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In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Key Success Factors include:

- Resource availability including health trainers and voluntary sector
- Training for resources in motivational interviewing/health coaching/patient activation
- 'Buy-in' from GP practices

Implementation Approach:

Wider Testing – Q3/4 2014-2015

The wider testing phase will run the programme in 30 GP practices across the city (approximately a quarter of practices). The practices are in the process of being agreed but will include some who already have a Health Trainer working with them as well as those who had aligned LCH staff attend a Health Coaching Training course in June 2014.

In Q3, learning and experience from the trial will be used to drive an analysis phase followed by solution design and development phases during which the programme and methodology will be reviewed and refined before testing the revised programme with the 30 GP practices in Q4.

Phase 1 Implementation – Q1 2015-2016

Learning and experience from the wider testing will be used to further review and refine the model before it is rolled out to a further 30 GP practices across the city (approximately half the practices)

Phase 2 Implementation – Citywide from Q2 2015-2016

Learning and experience from the Phase 1 implementation testing will be used to further review and refine the model before it is rolled out to the remaining GP practices across the city.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

To Proposal,

- Any delay in contribution of funding will impact on roll out/scaling up across the city and impact seen within this financial year
- This initiative is a key enabler to support practices with their 2% list and the new work that is generated through this without the additional investment the capacity and ability of community services to work with practices to deliver this GP contract change would be severely compromised
- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts/backfill.
- There is a risk that some GP practices will not 'buy in' to the model and may be resistant to adopting it.

- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal.
- The benefits stated are based on estimate/prediction rather than actual.
- The ability to track patients through the system. This will be mitigated initially by the use of the Risk Stratification tool with ongoing investigation into long term adoption of other possible tools i.e. CareTrak reports.
- Ability to specifically attribute savings to these proposals as opposed to savings in system per se.

To whole system,

- Whole system risk - impact of all proposed changes is not fully modelled or known at this time. Need to work closely to develop agreed indicators and processes to monitor the programme.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

The Better For Me project is being managed in accordance with the Leeds Community Healthcare NHS Trust Programme Management Office Project Lifecycle and follows 8 project stages:

Project Stage / Milestone	**Estimated Completion Date**
1. Idea	11/12/13
2. Initiation	30/05/14
'Proof of Concept' Trial	30/05/14
3. Analysis	27/06/14
4. Solution Design	01/08/14
5. Development inc. Communications & Training plans	28/11/14
6. Testing	27/03/15
7a. Phase 1 Implementation	26/06/15
7b. Phase 2 Implementation	25/09/15
8. Closure	06/11/15
9. Post Project Review	25/03/16

SCHEME NAME :- Enhancing Integrated Neighbourhood Teams (Increased Community Nursing Capacity to support care at End of Life and 7 day working)enhance 7 day working	
SCHEME NO	**16f**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	CCG - Andy Harris/Ian Cameron;
BUSINESS CASE AUTHOR/S	**Emma Fraser**
VERSION & DATE	**V0.3, 12/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

This business case seeks funding through the Better Care Fund to enhance and sustain a number of initiatives aimed at supporting the overall transformation of adult health and social care and local system change at scale and pace. The overall scheme will look to extend and enhance the role of existing neighbourhood teams in a range of ways to improve their focus on streamlining discharge and proactively managing patients in the community. The enhancement and development of a number of services will ensure that services are best placed to respond to 7 day working as it is further developed across the local health and social care system. This scheme will complement the primary care developments in reducing admission, readmission and act as a stronger "pull" in the system to safely discharge people from hospital and support their return home.

The individual proposals as outlined below collectively aim to improve patient experience, enable further change on the ground as part of our overall vision for service integration within the city and ensure the system works more effectively to meet demand.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The city of Leeds has embarked on an ambitious and challenging programme of transformational change relating to its provision of adult health and social care. The programme of change centres on responding to increasing demand, managing the needs of an ageing population often with one or more long term condition, operating in a climate of reduced resources and responding to what the people of Leeds say about their experience of services to date. Using the Sir John Oldham model of long term condition management an extensive process of consultation and engagement took place across the city to agree and sign off the vision for change. Referred to as

the Target Operating Model or TOM, the vision aims to respond to the challenges previously outlined and simplify the model of provision. In essence the TOM identifies a number of components which if successfully delivered would join up and enhance health and social care service provision within Leeds. These are:

- Provision of a single gateway or front door to improve access to services across health and social care
- Having in place a service that can effectively respond to people in crisis to make safe, maintain in their home with a package of health and social care focused on maximising independence through rehabilitation and reablement. Within our vision this is referred to as the rapid response service
- Working in a joined up way at the neighbourhood level centred on a registered GP practice population. Having the necessary skills within the team to respond effectively to the needs of the population in a proactive way that promotes health and wellbeing and maximises personalisation, choice and self-management supported by the appropriate professionals/agencies. Within this model the ability to provide case management to patients who require it is key as is working with other agencies both statutory and non-statutory within the neighbourhood
- Having an overall ethos/approach that is centred upon maximising people's independence through a model of goal centred intervention that recognises the significant asset the patient/service user bring to the delivery of the plan of care and its success. Equally the approach will focus on maximising independence through enablement focused on keeping the individual in their own home/community wherever possible/appropriate

Significant progress has been delivered over the last 2 years in terms of achievement of the overall vision for integrated services. This has involved considerable clinical engagement to lead, shape and develop the detail of the model to be delivered at the neighbourhood level.

This financial year is seen as a key period in terms of successful delivery of the remaining elements of our agreed vision, supported with an ongoing programme of development to ensure sustainability and delivery of success.

The opportunity to secure additional funding through the Better Care Fund is seen as a significant enabler in terms of adding to plans already in place or about to roll out with the additional money through BCF allowing these plans to go further and thereby have a move significant impact for both patients and the system.

This proposal is to increase the capacity in the community nursing service at a neighbourhood level (with a specific focus on district nursing services) supporting improved care for End Of Life (EOL) patients and 7 day working.

The service model for this proposal is to deliver the additional capacity to support the above areas within the developing Integrated Neighbourhood Teams (INT). Thirteen INTs are under development providing nursing, therapy and social work input at neighbourhood level, wrapped around GP practices. The additional posts will join the INTs and be managed within the INT leadership and management structure, ensuring that the additional capacity has maximum impact on patient care.

It is anticpated that the proposed funding will support additional posts as follows:

- 2.4 wte x administrators
- 23.5 wte community nurses

The exact staffing structure will be finalised as part of ongoing work to develop integrated neighbourhood teams. Commissioners will be kept up to date with changes to the planned staffing structure.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Commissioner – LSE CCG
Provider - LCH

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This proposal will expand capacity in integrated neighbourhood teams in order to work with primary care to:

- proactively manage people to live independently at home, reducing admissions and readmissions
- improve flow from acute settings to reduce length of stay and delayed transfers of care
- improve performance in meeting people's health needs as they approach the end of life

This increase in community nursing capacity will improve 7 day working and flow within the service.

The End of Life Health Needs Assessment (HNA) undertaken recently in the city recognised the current need to increase District Nursing capacity to deliver all aspects of end of life care. This includes capacity to manage the increased number of people approaching end of life and choosing to be cared for and die in their usual place of residence

To date there has been a reduction in the number of people dying in hospital nationally and in Leeds. Leeds ONS data referred to in the HNA shows a decrease in hospital deaths from 50.2% in 2007 to 48% in 2011. Deaths at home have increased from 19% to 21% over the same period.Increasing capacity within neighbourhood teams should enable this figure to continue rising.

This increased capacity will also enable the service to better support the earlier discharge of all patients and prevent admissions through proactive management. This will contribute overall to reducing acute activity and costs within the system
.

The key metrics that will be used to evaluate the impact and success of this scheme are;

- Patient satisfaction measures to be developed in line with the city wide work plan for End of Life care
- Improved adherence to Service Delivery Framework for End of Life Care, including bereavement support
- Increase the numbers of Independent Nurse Prescribers within neighbourhood teams actively prescribing for patients approaching end of life.
- Increase the number of nurses who can verify expected death within neighbourhood teams.
- Maintain current PPD target for an increasing number of End of Life Care patients cared for in usual place of residence
- On going review of citywide EoLC data collated by the CCGs from 2014/15 Q1 in line with HNA recommendations

During Q2 2014/15 Leeds Community Healthcare Trust will develop key metrics and baselines for the above indicators as the service model develops, in conjunction with commissioners.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

1.2m FYE (clinical resources and associate non pay costs)

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*

- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

All of the key stakeholders will be required to work in an integrated and collaborative way centred on the patient and their personalised care plan, in particular improving coordination of care for patients approaching end of life. The effective and consistent use of EPaCCS and implementation of the Leeds Care Record is critical to this.

A key relationship is between the acute hospital services and LCH – particularly in relation to the interface functions e.g. discharge planning

Neighbourhood teams are in the process of being established - this is part of the neighbourhood team offer and will be delivered as part of the Integrated Neighbourhood team.

Activity (what reductions in relevant activity will the proposal have expressed as numbers of people/% of current activity levels?)

- Estimated total additional activity for the additional resource would be c35,000 contacts (FYE), depending on the final service delivery model agreed. This increase in activity in the community should result in stopping people going to hospital unnecessarily and improving the patients experience.
- The proposals will improve other aspects of quality:
    - providing more early support to patients recognised as palliative;
    - potentially improving symptom control by increasing the numbers of Independent Nurse Prescribers actively prescribing for patients approaching end of life;
    - reducing the need for GP visits in and out of hours through this increased prescribing and more nurses being trained to verify expected death.

Increasing nursing capacity in the community is expected to allow between 300 and 500 more patients each year to choose to die at home rather than in hospital. Using NICE System Impact Modelling End of Life Tool, this additional support is expected to avoid 337 non-elective admissions. This figure is consistent with local intelligence for the opportunity saving associated with avoided non-elective admissions.

For illustrative purposes
The range of possible contacts is:

Minimum - 22,500 (based on x 1 daily contact for 1 month at intermediate stage and x 2 daily contacts for 1 week at intensive stage).
Maximum - 112,000 (based on x 1 daily contact for 3 months at intermediate stage and x 3 daily contacts for 2 weeks at intensive stage).
and obviously a whole range in between! There are a whole load of variables within that range.
This is based on an assumption of 500 patients a year.

Based on the investment proposed and using current average number of contacts per WTE based on the current contract for DN -24 services.
The proposed investment buys 23.5 WTE clinical staff (based on B5). we know that in reality we are likely to further skill mix this to provide best overall skill mix in developing Integrated Neighbourhood Teams. Working on assumption of 23.5 WTE the revised proposed total increase in F2F contacts would be in the region of 35-40,000.
For illustrative purposes this could be broken down as follows:

1 month x1 contact daily (15,500 contacts) +2 weeks x 2 daily contact (14,000 contacts) + 4 days x 3 daily contacts (6,000 contacts) = 35,500 contacts
If additional contacts were required (nearer the 50,000 level), additional investment would be required accordingly to increase the WTE capacity available.

COST

The cost benefit analysis will need to be undertaken with commissioners as part of the wider system planning linked to the Transformation Programme.

BCF IMPACT

BCF National conditions

- **Plans to be jointly agreed.** The proposals respond to the implementation of the Target Operating Model for integrated adult health and social care services, which has been agreed at the Transformation Board.
- **Protection for social care services.** The proposals include funding for health and social care resource as part of integrated working at neighbourhood level and to support discharge planning
- **7 day services to support discharge and reduce admissions.** Many of the schemes included in the Enhanced Neighbourhood Team proposal specifically increase capacity at weekends and out of hours to support timely discharge and reduce risk of admission.
- **Better data sharing between health and social care based on the NHS number -** The integrated neighbourhood team model is based around a multi-disciplinary team, including both health and social care, working closely together to deliver a programme of care. The NHS Number has been agreed as the common currency between the different organisations. This work is support by on-going developments in information governance and data sharing between health and social care organisations in Leeds, lined to pioneer status and Leeds Care Record.
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- **Agreement on the consequential impact of changes in the acute sector.**

The proposals outlined are designed to reduce the overall number of acute beds required and reduce length of stay through a more proactive, community based response. The overall impact and management of this will have to be monitored closely between commissioners and providers.

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- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Successful recruitment of the community nurses

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- A lot of change is being undertaken at the same time within community nursing and the neighbourhood teams - interdependencies with this work.
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts. This is being mitigated by increased recruitment resources and staff being recruited on a permanent contracts (risk to be shared with commissioners).
- The benefits stated are based on estimate/prediction further work is required over the coming months across the system to finalise the benefits.
- An increase in the numbers of patients approaching end of life being supported by integrated neighbourhood teams is dependent on earlier identification and referral of patients by other services
- Ability to specifically attribute savings to these proposals as opposed to savings in system per se

- Whole system risk. Total impact of proposed changes is not fully modelled or known at this time.

PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
It is planned that this scheme/additional capacity will be in place by the beginning of Quarter 3 2014/15

SCHEME NAME :- Frequent Flyers	
SCHEME NO	**17a**
RESPONSIBLE GROUP	**Debra Taylor Tate**
ACCOUNTABLE LEAD OFFICER	**Nigel Gray / Jason Broch**
BUSINESS CASE AUTHOR/S	**Matt Storey**
VERSION & DATE	**1.0 10/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Working from the point that frequent users of urgent care services are either frequently ill or are using Urgent Care services frequently due to disengagement with other more appropriate services, it becomes clear that urgent care usage is a symptom of a larger problem rather than a problem in itself.
More robust multi-agency case management will allow this cohort of service users to achieve better outcomes, which will be reflected in their decreased use of Urgent Care services.

This contributes towards the BCF national conditions of data sharing and use of NHS number and Joint care assessments, as well as contributing towards the aim of reducing emergency admissions by 3.5%, reducing delayed transfers of care, and improving Patient and service-user experience. At a local level this scheme also contributes to HWB targets 1 – 4 (People will live longer and have healthier lives; People will live full, active and independent lives; People will enjoy the best possible quality of life; People are involved in decisions made about them)

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

To ensure best use of resources it is proposed that this resource is used to commission a case management coordinator from a third party organisation that already has the appropriate information governance arrangements in place with the necessary stakeholders (see below)

This scheme will target individual high volume users of urgent care services for whatever reason. Exact thresholds are yet to be defined but the case management coordinator will work with the CCG and providers to target those where the highest system benefit will be realised. The coordinator will work across all urgent care providers in Leeds to map the service usage of individuals in order to ensure that the most appropriate individuals are targetted

Projected volumes of service users are difficult to calculate. In a snapshot assessment it was found that the 5 highest users of ED services at LTHT accounted for over 500 attendances per month. It is

nationally recognised that these high volume service users tend to use services intensively for a short time, then they are replaced by another high volume service user. It is therefore anticipated that the workload for this post will continue as new patients present to the system.

LNCCG will identify who this service is to be commissioned from. Likely partners may include LYPFT or West Yorkshire –Finding Independence (WY-FI), who both have established multi-agency working procedures and extensive case management experience

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The Urgent Care team (based at LNCCG) will deliver the initial business plan and service spec, and then commission and monitor delivery of this scheme on behalf of the city
The provider organisation will be responsible for delivering the multi-agency case management. We are cogniscent of the challenges that the very high volume service users present, and that this may make case management extremely challenging. It should therefore be explicitly recognised that - in the pilot phase – patient outcomes will be monitored but not commissioned as a KPI.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

A snapshot of A&E data indicates that the five highest users of ED services at LTHT account for over 500 presentations a month collectively. Some of these presentations will include 999 activity, investigations and admissions to hospital. As well as the explicit impact of high-volume service users there is also the comparatively hidden impact of these users diverting resources away from other service users

Multiple research papers indicate that a case management approach can help reduce attendances in this group by between 30-70%, resulting in a drop in overall A&E attendances of between 1 and 2 % (2000-4000 attendances, circa £200,000-£400,000 cost saving based on average A&E tariff), with similarly reduced admission rates and impact on other services. Once this is expanded to include lower volume frequent service users and frequent users of other services it is clear that this post has the possibility of significantly improving individual's outcomes, and thus creating

significant system efficiencies.

Key Metrics Required,
Presentations to urgent care (by user)
Tariff applied to each presentation
Outcome of each presentation
Total financial cost of each presentation
Level of intervention by other services (Social Services, Council, Police etc)

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

Key investment is to fund a project manager to establish the Data Sharing and Data Management Agreement between providers, and to then provide the ongoing coordination and support of the multiagency process. It is anticipated that this could be a Band 5 Project Support role at a cost of £27,901, supported by a band 3 admin assistant at a cost of £19,268

Total projected staffing cost : £47169

SystmOne Setup & licence for 1yr : circa £30,000

Total costs (est) : £77,169

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Multiagency cooperation between all health and non-health agencies will have to be assured to ensure that care plans are appropriate to the stated aims, and are applied consistently. It is anticipated that input will be needed from
LTHT
LCH
YAS (111 & 999)
LCD
Malling Health (provider of WiC services at The Shakespeare Medical Centre)
Adult Social Care

Leeds Addiction Unit
LYPFT
Dial House
Volition
Leeds City Council
West Yorkshire Police

Plus other agencies (for example third sector organisations) as required on a case-by-case basis

Activity,

As already stated the "top 5" attenders at LTHT EDs account for over 500 presentations a month (6000/year)against a 2012/13 ED attendance figure of 190,012 (Leeds Residents only) this equates to activity of 3.15% of total demand . Assuming 250 of these presentations also involve ambulance use this equates to 2.67% of YAS activity.
No indicative figures are available (at time of writing) for activity reductions in other providers, and it should be noted that these figures only apply to the top 5 attenders at LTHT
It is difficult to make activity assumptions as not all activity may be reduced/eliminated and other (lower volume) users have not been factored in.
If benefits can be realised it is possible that this scheme in isolation could deliver a significant reduction in ED admissions, possibly totalling or exceeding the 3.5% reduction required (approximately 2454 ED admissions, but more if non-elective admissions direct to assessment units/wards are taken into consideration)

COST

It is key to understand that some of the projected savings may not be fully recouped, in that the savings made may be absorbed into improving normal service delivery, and funding may have to be redirected for individuals to deliver more appropriate treatments/interventions

Provider (Service)	Episodes p/a	Indicative Cost (average)/£	Total Saving/ £
LTHT(ED)	6000	100	600,000
YAS(999)	3000	227.66	682,980
LTHT (Short Stay admission)	600	694	416,400
			1,699,380

As with activity it is difficult to provide any solid figures for costs reduction as there are viable reasons why no impact may be seen, and equally the figures may be significantly above those quoted when the wider population is considered

On BCF,
No negative outcomes predicted. Potential positive outcomes against emergency admissions targets.

FEEDBACK LOOP
What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

As previously mentioned, due to the challenges these individuals present, no change in service usage may be seen. Therefore the contractual measures used for the scheme will be agreed milestones between the service provider and the CCG for the establishment of the Case Management process. Individuals' service usage is readily available from Business Intelligence colleagues (CCG and provider) through existing arrangements and should provide the baseline for impact measurement. It is not practicable or ethical to establish a control group due to the number of variables that influence service use. However it may be possible to use the service usage of individuals who opt out of the process to compare service use trends.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The service spec for the provider organisation should establish that they have established skills, links and data sharing agreements with the necessary partners (including service users) in order for this to be a success. They will also have to demonstrate that they have responsive and easily replicable IG arrangements in place in order to robustly establish any new links that may develop during the course of the programme.
It is projected that service spec will take 1 month to draw up, a further month to then identify our preferred provider, and a further 2 months for recruitment and selection, with staff therefore starting in post 4 months after scheme approval

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Agencies (especially non-health) not engaging in process

- Failure to agree a data sharing or data management agreement
- Agreed care/intervention plans not followed
- Difficulties funding different interventions, especially if it means redirecting funding from one provider to another

- Reported performance may be negatively affected as the management of these high volume patients may positively contribute to performance figures

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Realistically we would aim for the project to start in April 2015 with the pilot to run through a full financial year. This may be accelerated if funding has to be realised in this financial year.
Once this scheme is approved the Urgent Care Team can draw up a full business case and service spec within 1 month, with further development work to take place in partnership with the provider.

SCHEME NAME	**Community Pharmacist Minor Ailments scheme**
SCHEME NO	**17b**
RESPONSIBLE GROUP	**Strategic Urgent Care Board**
ACCOUNTABLE LEAD OFFICER	**Nigel Gray**
BUSINESS CASE AUTHOR/S	**Debra Taylor-Tate**
VERSION & DATE	**Version 2, 9 Sept 2014**

STRATEGIC OBJECTIVE OF THE SCHEME :

The transformation of urgent care services in line with the national review.

OVERVIEW OF THE SCHEME

The Pharmacy First service is a locally tailored scheme where patients are encouraged to consult a participating community pharmacy, rather than accessing their GP or urgent care, for a defined list of common ailments. The pharmacist will give advice and supply medication from an agreed formulary, or refer the patient to the GP if necessary.

If patients are exempt from NHS prescription charges, medicines are supplied free of charge. Therefore, the payment barrier, which can prevent patients choosing to see a pharmacist instead of their GP or accessing urgent care, is removed. If the scheme is also open to patients who normally pay prescription charges, they will pay a prescription charge for each medicine supplied.

Minor ailment schemes benefit patients, since they receive quick expert advice in the pharmacy without the need to make an appointment with their GP or Local Care Direct. This will hopefully allow GPs to spend more time focusing on those patients that really need their input, managing long term conditions and improving access. This will have a beneficial impact on both GP access and reduce the burden on urgent care. In addition, such schemes promote the role of the community pharmacist as a medicines expert to patients, practice staff, GPs and other health care professionals.

THE DELIVERY CHAIN

The service will be provided across Leeds through Community Pharmacy West Yorkshire (CPWY). Services will be delivered by individual pharmacy organisations governed by CPWY. Leeds North will be the lead commissioner as host of Urgent and emergency services

THE EVIDENCE BASE

This service has been running since January in NHS Bradford City CCG. A three month evaluation has just been completed and shows:

Overall, in the first 3 months, Pharmacy First scheme has shown to be a cost-effective way to manage patients presenting with minor ailments. A high number of consultations for minor ailments were delivered through this service with the estimated release of over 1825 GP consultations. Diverted A&E and walk-in consultations have already saved £2115. Most of the patients were under 10 years old

with over half of those being under 5 years.

The majority of patients were treated for self-limiting viral symptoms such as cough, cold, sore throat and fever and were provided with symptomatic relief for their symptoms, keeping them out of a service environment. The cost for medication was low (per patient £1.78 and per item £1.18). Including the service fee of £4.50 this equates to an average consultation cost per patient of £6.28.

INVESTMENT REQUIRED

Funding

Minor Ailment Consultations	12,500	£56,250
Drug Cost	12,500 (Average cost £2)	£25,000
Project management	Implementation and ongoing support	£7,800
Service administration and data collection	£4 per pharmacy per month	£1,920
Total funding		£90,970

IMPACT OF THE SCHEME

Improve access for patients, promote pharmacy as an alternative to GP practice, Out of Hours service and A&E reducing pressure on and cost to the urgent care system by shifting demand to a more appropriate setting.

Benefits of a community pharmacy minor ailments scheme:

- Promotes self-care through pharmacy, educates and empowers patients in caring for themselves
- Provides access for patients to appropriate advice and/or treatment
- Improves primary care capacity by reducing GP practice and OOH services workload related to minor ailments
- Can integrate with NHS111 and Directory of Services to reduce pressure on urgent care and reduce A&E attendances
- Improves access to medicines and increase choice of primary care services
- Improves GP access for patients with more complex conditions
- Promotes better working relationships between community pharmacists and the wider Health Economy

Improvement CCG outcome indicator 4ai (Patient experience of GP services) and indicator 4aii (Patient experience of GP out of hours service) would be expected.

Shift of patients to pharmacy services would provide effective care closer to home where appropriate improving the patient experience and outcome as well as reducing pressure across both the primary care and the acute sector.

FEEDBACK LOOP

-

Pharmacies:

- *Number of pharmacy attendances for minor aliments*
- *Number of patients who would have gone to a GP if no alternative*
- *Patient experience*
- *Number of pharmacy Re attendances*
- *Number of patients referred through 111*

Collected through MDS and patient survey

OOH services

- *Reduction in overall attendances*
- *Reduction in attendances referred by 111*
- *Data collected through contract process*

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- **Shift in patients behavior to self care**
- **Geographical spread of participating pharmacists offering services**
- **Promotion by all health professionals**
- **Effective evaluation and monitoring to inform further commissioning intentions**
- **Integrated in the 111 DOS, YAS pathfinder**

KEY RISKS

- This funding is only available for delivery of the service 14/15 which may make it difficult to recruit pharmacies as there is limited time to have a return on investment
- Short delivery period will make patient awareness difficult and just as patients become used to the service it may not be recommissioned
- Controls will be required in the service to ensure that spend does not exceed budget. This will be supported by Community Pharmacy West Yorkshire

These risk have been successfully mitigated during the implementation of this service currently running in West Yorkshire.

PROPOSAL IMPLEMENTATION PLAN

-

- *Quarter 3 2014/15 expressions of interest, service specification, contract*
- *Quarter 3/4 evaluation*
- *Quarter 4 future commissioning decision to continue project*

SCHEME NAME	**Improved Information Governance**
SCHEME NO	**18a**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

-Maximising the use of new technologies that identify risk, integrate care records and support self-care [5 Year Strategy].
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

To add a dedicated Information Governance management/advisory resource to 'join up ' the organisational information governance arrangements across the city and coordinate joint 'products' that are required for integrated working and improved information sharing.

Starting as temporary resources and making the case for ongoing, recurrent support .

Delivery during 14/15 and interfacing between Health and Social Care.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This extra capacity will be hosted by Leeds North CCG.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*

- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Especially working alongside other Integration Pioneer cities, the need for this expertise is apparent.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£60,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The addition of this specialist expertise will assist in 'unblocking' and enabling the sharing of information across health and social care and across other transformation initiatives. This work is an enabler for further transformation.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

The Leeds Informatics Board
City-wide Information Governance network (to be established)

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The current limitations within the Law and H&SC Act
Expertise
Attracting staff if non-recurrent funding continues.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Expertise
Attracting staff if non-recurrent funding position continues.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

1 April 2014 – Secure temporary expertise
Deliver new Information Sharing Agreement (ISAs) between Health and Social Care to support the Leeds Care Record
Establish City-wide Information Governance network
1 October – Make case for recurrent support
Develop/agree a city-wide approach to ISAs

SCHEME NAME	**Improved business intelligence – city wide analytical resource**
SCHEME NO	**18b**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

- We will continue to develop meaningful measures for the systems and the component parts to ensure that we are able to understand the impact of our actions. This will continue to include Outcomes Based Accountability as well as analytical and modelling tools. [5 Year Strategy]
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

To add a dedicated Analytical resource to support the more sophisticated elements of Analytics including Economic Modelling, metrics definitions, Insights and Intelligence, 'tools' that bring together Health and Social care data for joint analysis.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This extra capacity will be a combination of ring-fenced capacity from existing health and/or social care staff, the use of specialist contractors and service providers.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*

- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Evidenced-based decision making

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£370,000

Seconded staff
Contractors
Licences
Commissioning Support Unit capacity

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Assessment of the city-wide financial gap
Assessment of the possible impact of transformational scheme
Assessment of the actual impact of transformational scheme
Insights in to opportunities to design new transformational schemes
Tracking of the BCF

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Transformation Board
Transformation Programmes/Projects
The Leeds Informatics Board
City-wide Intelligence Steering Group

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The current limitations within the Law and H&SC Act for data for commissioners
Availability of data
Expertise
Attracting staff if non-recurrent funding continues.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Availability of data
Expertise
Attracting staff if non-recurrent funding position continues.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

1 April 2014 – Secure temporary expertise
Develop an Economic Model
Develop a H&SC 'dashboard'
Assist transformation programme to select reporting methodology e.g. OBA
Assist transformation programmes to assess scheme impacts
Assist transformation programmes to design metrics
Establish City-wide Intelligence Steering Group

1 October – Make case for recurrent support

SCHEME NAME	**Leeds Care Record (LCR) – go-live phase and further developments**
SCHEME NO	**18c**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

-Maximising use of new technologies [5 Year Strategy]
-Maximising the use of new technologies that identify risk, integrate care records and support self-care [5 Year Strategy]
-Using the latest technology to enable patients to be seen by the right professional at the right time in the right place [5 Year Strategy]
-Using technology enablers to improve patient care and efficiency [5 Year Strategy]
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

Leeds Care Record is a direct patient care facility that provides 'view' access to clinical information from primary and secondary care via a single 'portal'.

This funding is to rapidly roll-out the Leeds Care Record to all GP Practices, LYPFT, LCH and some neighbourhood teams.

It will also improve the functionality of the LCR to enhance the facilities available for integrated care.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The LCR is a system/service that is developed by Leeds Teaching Hospitals, commissioning by the Leeds Informatics Board.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

There is significant evidence that clinicians accessing information at the earliest and most appropriate point in the patients' pathway will lead to better clinical decisions and lead to reduced inappropriate admissions, duplicated clinical effort, earlier discharges etc.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£450,000

Project Management
Communications and Engagement
Training and awareness
Various technical developments
Service Desk

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

-Better informed patients – obtaining information from their GP rather than contacting the hospital
-Better informed GPs leading to – fewer duplicate tests, better care decisions, fewer admissions
-Improved information for out-of-hospital clinicians – fewer duplicate tests, better prescribing, reduced admissions
-Improved information for hospital clinicians – better prescribing, earlier admission
-Improved neighbourhood teams

Example of financial benefits:-

433 GPs save 1 test per week by having access to improved information = £338,000 per annum
200 out-of hospital clinicians, as above = £156,000

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Transformation Board
Transformation Programmes/Projects
The Leeds Informatics Board
Leeds Care Record Project Board

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

GP engagement
Understanding of data sharing and consent

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Confusion on data sharing and consent esp. care.data
Patients opting out of sharing due to poor understanding/poor communication
Lack of GP engagement

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

55 GP Practices live by end-August
100 GP Practices live by end-March
200 out-of hospital clinicians live by end-December

SCHEME NAME	**Programme Management**
SCHEME NO	**18d**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

-Maximising use of new technologies [5 Year Strategy]
-Maximising the use of new technologies that identify risk, integrate care records and support self-care [5 Year Strategy]
-Using the latest technology to enable patients to be seen by the right professional at the right time in the right place [5 Year Strategy]
-Using technology enablers to improve patient care and efficiency [5 Year Strategy]
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

Above and beyond the Leeds Care Record, there are a number of technology improvement initiatives taking place in the city that form part of the Leeds Informatics Board portfolio. This funding allows for:

- Administration of the Leeds Informatics Board
- Regular contact with hospitals, adult and children's social care to ensure that technology strategies and projects remain aligned to deliver maximum benefits
- Production/coordination of bids for additional funding e.g. NHS England Technology Fund
- City-wide Programme Management Group
- Coordination of a portfolio of improvement projects
- Links to Integration Pioneer work and Smart Cities initiative

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Currently using contract resources

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Leeds as a city has gained substantially from having a visibly 'joined up' and integrated Informatics agenda. This has enabled organisations to gain from national funding, gain from national support etc.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£85,000

Project, Programme Management, Project Support and Administrative resources.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Enabler for city-wide working and the benefits that continue to arise from a high national profile in this field.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of*

the proposal to your overall objectives? - *Can you set up a counterfactual or control?* - *Will data be generated automatically or does it require a new survey / data collection approach?*
Transformation Board Transformation Programmes/Projects The Leeds Informatics Board Leeds Care Record Project Board
KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME - *E.g. expertise, staff, demographics, history of partnership working.* - *Do these also exist within the local area?* - *If not – have actions been put in place to resolve this?* - *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?* - *An outline of a stepped approach to implementation which draws on* *I) learning from either local evaluation or other areas where this has been implemented, and* *ii) engagement with partners about the deliverability of the proposal*
All health and social care organisations working in an open and transparent way, sharing visibility of investments, strategies etc.
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
Availability of quality temporary resources
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
Regular contact with all health and social care organisations Quarterly Informatics Boards Quarterly Programme Management Group meeting Bid for NHS E Tech Fund 2 resources

SCHEME NAME :- 19	
SCHEME NO	Care Act (2014)
RESPONSIBLE GROUP	**Care Act Programme Board**
ACCOUNTABLE LEAD OFFICER	**Sukhdev Dosanjh**
BUSINESS CASE AUTHOR/S	**Sukhdev Dosanjh**
VERSION & DATE	**V2, 11/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

1.Care Act will make a positive contribution to the priorities set out in the Joint Health and Wellbeing Strategy. The definition of wellbeing set out in the Act together with its practical impact will greatly assist in the delivery of the key priorities. The themes of empowering individuals through personalised care and developing care services that best fit around their lives. This in turn will help to prevent, reduce or delay the need for statutory care services. The Government expects people dealing with adult social care to be able to articulate clear outcomes from their experience through "I" statements:

- "I am supported to maintain my independence for as long as possible";
- "I understand how care and support works, and what my entitlements and responsibilities are";
- "I am happy with the quality of my care and support";
- "I know that the person giving me care and support will treat me with dignity and respect";
- "I am in control of my care and support and I have greater certainty and peace of mind knowing about how much I will have to pay for my care and support needs".

The main provisions in the Care Act set out above will make a positive contribution to the achievement of the priorities set out in the Joint Health and Wellbeing Strategy. Of particular relevance are the priorities relating to: the number of people supported to live in their own home; more people recover from ill health and ensure people cope better with long term conditions; ensure that people have voice and influence in decision making and increase the number of people who have more choice and control over their health and social care services.

2. The delivery of the Better Lives Programme with its core aim of helping local people with care and support enjoy better lives is one of the Best Council Plan 2013-17 objectives. The Better Lives focus is on giving choice and helping people stay living in their own home, joining up health and social care services and creating the right kind of health and social care support. The Better Lives Programme continues to drive whole systems change within the Leeds health and social care economy and is aligned with the Care Act reforms. It is clear that the reforms will require the Council and its local health and care partners within the City to increase the scale and pace of its transformation programme notwithstanding funding pressures.

The Care Act implementation programme will address the following City priorities with a particular impact in respect of health and wellbeing, business, and communities. The reforms seek to:

- Give people choice and control over health and social care services through personalisation provisions;
- Support the sustainable growth of the Leeds' s economy in terms of stimulating innovation in the care sector and
- Stimulate community empowerment and cohesion through building on the Neighbourhood Networks and encourage the development of prevention schemes.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The Care Act (2014) sets out a fundamental review of the law as it relates to care support and planning. The provisions within the Act contain new legal duties, powers and responsibilities as they relate to:

1.The promotion of well-being duty

Adult social care is now to be organised around the well-being of the individual. In effect, 'well-being' is the single unifying purpose around which all adult social care services are to be arranged.

2.The prevention duty

This duty seeks aims to address a key finding in the White Paper in that too often the adult social care system only reacts to a crisis. The Council will have a duty to prevent, reduce or delay the need for on-going care and support. There should no longer be an assumption that all care pathways lead inevitably to institutionalised acute care.

3.Assessments & Eligibility

A national eligibility criteria will be set where a minimum threshold will determine the care needs that will make an individual eligible for the Council's support. Assessments will be revised and expanded, which will mean that there will be a requirement to re-assess people who move into Leeds from another area (principle of portability); assess a large number of self-funders (people who have means to fund their own care); and have a duty to carry out more carers' assessments under the new Carers' eligibility criteria.

4.Prisoners

The Act establishes that the local authority in which a prison, "approved premises" or bail accommodation based will be responsible for assessing and meeting the care and support needs of the offenders residing there if they meet the eligibility criteria.

5.Carers

The Act places Carers on an equal footing with the people they care for. Carers' entitlements and rights are to be enhanced in law with a duty to provide services are to be strengthened following a determination of eligibility under a new Carer's eligibility criteria;

6.Charging and the lifetime cap on care costs

A lifetime cap on care costs will be put in place for people receiving the State Pension which it is proposed is set at £72,000 after which the Council will meet the costs of care. The cap will consist of care costs only and will not include accommodation costs. There will be a duty on the part of the Council to provide a care account which records care costs and track progression towards the care cap.

The "asset threshold" (this is an individual's collective worth e.g. house, savings, benefits and pension) for those who in residential care, beyond which no means-tested help is given, will increase from £23,250 to £118,000. In effect, a more generous means test.

7.Duty to Promote Integration

The integration agenda maintains a strong focus in the Act with the introduction of a duty on the Council to carry out its care and support responsibilities with the aim of integrating services with local

NHS partners.

8.Self-funders

The Act introduces a duty on the part of the Council to meet the needs of self-funders (those people who have means to fund their own care) if they request assistance. The duty to provide advice and information set out below extends to people who have means and are planning how best to meet their future needs care.

9.Advice and Information

The Council has now a duty to advise and inform people so that they can better plan for their future care needs, gain a greater understanding of the adult social care system and improve their access to services.

10Choice and Control

Personal budgets will be enshrined in law for the first time and create a duty on the part of the councils to include them in a person' s care and support plan.

11.Shaping Care Markets

The Act places new duties on local authorities to facilitate and shape their care market for adult care and support as a whole. Councils must meet the needs of all people in their area who need care and support, whether arranged or funded by the state or by the individual themselves.

12Adults Safeguarding

Safeguarding arrangements will be strengthened by placing adults safeguarding boards on a statutory footing and creating a legal duty on the part of the Council to investigate suspected abuse when an adult is deemed to be at "risk of harm".

13Deferred Payments

The act extends deferred payment agreements which allow people to meet their own costs without having to sell their homes in their lifetime regardless of eligibility.

Leeds has initiated a programme of work for implementing the Care Act (2014). The Programme consists of several workstreams which focus on delivering the different aspects of the Act and is overseen by a multi-agency Care Act Programme Board (CAPB) chaired by the Director of Adult Social Services. The programme consists of work with a broad range of stakeholders to: understand and model the impact of the Act; determine the Leeds response to the act taking into account the draft guidance and technical regulations and develop options for how the new duties are best met in Leeds. The workstreams reflect the key priority areas as: 1. Carers; 2. Assessment and Eligibility; 3. IM&T as an enabler; 4. Information and advice, 5. Advocacy 6. IM&T 7.Finance and Metrics 8. Consultation, Engagement and Communication 9. People (OD &HR) 10. Strategic Commissioning 11. Legal Workstream 12. Gateway to Services workstream.

(Care Act (2014) Governance Arrangements, Care Act (2014) Governance Map, Care Act (2014) Project Plan are attached.)

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The implications of Care Act (2014) on our health and social care partners have been considered in a number of joint forums such as the Leeds Health and Wellbeing Board, The Integrated Commissioning Executive and the Transformation Board.
All of our schemes to date in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA. Any Service developments which arise from the Care Act (2014) in Leeds will follow this tried and tested pathway.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The Care Act (2014) is a statutory requirement set by the Government. The Care Act (2014) programme of work is currently in its options/appraisal stage. This stage consists of detailed business analysis, business process review and forecasting. This will help to inform demand and capacity planning, particularly as they relate to carers, assessment and eligibility and self-funders (people with means to fund their own care).

It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for October/November. Following this phase of the programme and a consideration of the options presented, the Leeds health and social care community will make key decisions on how best the new duties will be met. The key objective being to create a sustainable quality health and social care system which effectively discharges the new legal duties and responsibilities set out in the Act.

Key metrics are currently being developed and reviewed using national, regional and local tools. This will help to ensure that key decisions made in strategic are well informed.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

The Funding required from the BCF is £2.6m -£1.9m (Revenue) and £0.7m (Capital).

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The Consultation, Engagement and Communication Strategy for the Care Act (2014) is attached as an appendix. The strategy sets out the national timeline and milestones; the proposed consultations; communication strands; risk management issues and benefits. It has been developed based on the principles set out in the Council's Engagement Toolkit. The purpose of the strategy is to:

- engage key stakeholders (including service users and carers) to raise awareness of the provisions within the Care Act 2014 and how they affect health and adult social care services;
- make the best use of existing community networks, engagement forums and boards highlighted above to ensure that the direct experience of service users and carers as "experts by experience" help to shape and improve services;
- ensure that the implementation of the Care Act (2014) locally and what it means for the people in Leeds is consistent with the milestones and public awareness programme set nationally and regionally; and
- provide an assurance that the Council fulfils it legal obligations set out in the Local Government and Public Involvement in Health Act (2007) and the Equality Act (2010).

(The Phased Consultation, Engagement and Communication Plan for the Care Act (2014) is attached.)

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

The Care Act (2014) is a statutory requirement set by the Government. The Care Act (2014) programme of work is currently in its options/appraisal stage. This stage consists of detailed business analysis, business

process review and forecasting. This will help to inform demand and capacity planning, particularly as they relate to carers, assessment and eligibility and self-funders (people with means to fund their own care).

It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for October/November. Following this phase of the programme and a consideration of the options presented, the Leeds health and social care community will make key decisions on how best the new duties will be met. The key objective being to create a sustainable quality health and social care system which effectively discharges the new legal duties and responsibilities set out in the Act.

Key metrics are currently being developed and reviewed using national, regional and local tools. This will help to ensure that key decisions made in strategic are well informed.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The Care Act (2014) is a statutory requirement set by the Government. The Care Act (2014) programme of work is currently in its options/appraisal stage. This stage consists of detailed business analysis, business process review and forecasting. This will help to inform demand and capacity planning, particularly as they relate to carers, assessment and eligibility and self-funders (people with means to fund their own care)..

It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for October/November. Following this phase of the programme and a consideration of the options presented, the Leeds health and social care community will make key decisions on how best the new duties will be met. The key objective being to create a sustainable quality health and social care system which effectively discharges the new legal duties and responsibilities set out in the Act.

Key metrics are currently being developed and reviewed using national, regional and local tools. This will help to ensure that key decisions made in strategic are well informed.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

(Please see the Care Act (2014) risk register) example extract below:

Version						Assessment prior to mitigating actions					Assessment of risk if mitigating actions are undertaken				
Ref	Project	Work Stream	Type of Risk	Risk Response	Description of Risk	Probability	Impact	Risk Rating	Proximity	Mitigating Actions	Probability	Impact	Risk Rating	Proximity	Risk Status (open / closed)
CC1 - R14	Care Act	Care Act	Statutory Duties/Regulatory	Treat/Adapt	There is a risk the implamentation of statutory duties are not implemented legally.	3	5	15	Project Stage - 4 Delivery	A legal workstream has been established. Adult Social Care's corporate lawyer is part of this group to advise on the legality of options.	2	2	4	Project Stage - 4 Delivery	Open
CC1 - R15	Care Act	Care Act	Statutory Duties/Regulatory	Treat/Adapt	There is a risk that other directorates are not being consulted with in relation to their joint responsibilities for elements of the Care Act (i.e. Housing and Children and Young Persons Social Care.	3	3	9	Project Stage-1 Project Assessment to 6 Post Project Review	Sukhdev Dosanjh to engage with other directorates to establish a suitable officer to be responsible for the Care Bill.	2	2	4	Project Stage-1 Project Assessment to 6 Post Project Review	Open
CC1 - R10	Care Act	Care Act	Statutory Duties/Regulatory/ Legal	Treat/Adapt	The timescales given from the issue of the supporting guidance to implementation will be too short to undertake interpretation and delivery.	3	5	15	Project Stage - 4 Delivery	Undertake forward planning and identify the resources required to implement change. Consult with the National Projects to get as much advice and lead time as possible.	3	4	12	Project Stage - 4 Delivery	Open
CC1 - R5	Care Act	Care Act	Technical / ICT	Treat/Adapt	The new requirements of the Care Act could not be taken into consideration for the initial development of CIS given that these were not known at the time the CIS specification was developed. This may also be the case for other IT developments too e.g. e-brokerage/monitoring systems. There is a risk that the CIS workflow will not be consistent with process changes required to be compliant with the Care Act.	5	4	20	Project Stage - 4 Delivery	New requirements will need to be identified asap to anable the possibility of these being addressed as Day 2 CIS development.	2	4	8	Project Stage - 4 Delivery	New Issue
CC1 - R6	Care Act	Care Act	Technical / ICT	Treat/Adapt	There is a risk that the models coming out of the Care Act for Leeds may be different from that of Calderdale and that Calderdale's implamentation of changes will not be compatible with Leeds processes.	4	4	16	Project Stage - 4 Delivery	Identify differences between Leeds models of service and Calderdale. Any required development costs need to be estimated as part of options appraisals and funding identified when options are agreed. A Calderdale Joint Strategic Board has been established to manage	3	4	12	Project Stage - 4 Delivery	Open
	Care Act			Treat/Adapt	Risk that all the clauses for the Care Act are not reviewed.	3	4	12	Project Stage- 1 Project Assessment to	SME leads have been identified to review the clauses by mid-September '14.	2	3	6		

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

(See Care Act (2014) Project Plan) example extract below:

ID	Task Name	Start	
1	**Delivering the Caret Act 2014 High level Programme Plan (v1.10)**	**Mon 07/10/13**	**Fri**
2	**National/Regional Legislation / Guidance**	**Fri 14/03/14**	**Fri**
3	Children an Families Bill Royal Ascent	Fri 14/03/14	Fri
4	Major: Care Bill Royal Ascent	Wed 14/05/14	Wed
5	Major: Consultation on secondary guidance and legislation published	Fri 06/06/14	Fri
6	Major: Response to consultation of secondary guidance legislation closes.	Fri 15/08/14	Fri
7	Major: Secondary guidance and regulations published	Wed 01/10/14	Wed
8	Major: Care Bill provisions in force (Excluding Cap)	Wed 01/04/15	Wed
9	Major: Care Bill Cap provisions in force	Fri 01/04/16	Fri
10	Major: National Stocktake 1	Fri 16/05/14	Fri
11	Major: National Stocktake 2	Fri 17/10/14	Fri
12	Major: National Stocktake 3	Fri 16/01/15	Fri
13	**Programme Management**	**Mon 07/10/13**	**Mon**
14	**Programme Governance (collapse down and not on graphical plan)**	**Thu 13/03/14**	**Thu**
20	**Initial Care Bill Gap analysis (completed)**	**Mon 07/10/13**	**Thu**
33	**Equality Impact Assessment**	**Wed 22/01/14**	**Mon**
34	Complete Impact screening tool	Wed 22/01/14	Mon
35	Task: Equality Impact Assessment	Tue 11/11/14	Mon
36	Major: Equality Impact Assessment complete	Mon 16/03/15	Mon
37	**General/Ad-Hoc tasks**	**Fri 06/06/14**	**Fri**
38	Task: Review draft secondary guidance and legislation	Fri 06/06/14	Thu
39	Major: Consultation on secondary guidance and legislation ends	Thu 14/08/14	Thu
40	Task: Review secondary guidance and legislation	Wed 01/10/14	Tue
41	Major: Review of secondary guidance and legislation complete	Fri 31/10/14	Fri
42	Major: Sign off of operational models post review of guidance	Fri 31/10/14	Fri
43	**Risk Issues and Management**	**Mon 14/10/13**	**Fri**
46	**Delivery**	**Mon 21/10/13**	**Fri**
47	**Workshops**	**Fri 16/05/14**	**Fri**
52	**IM&T Workstream**	**Mon 02/06/14**	**Fri**
53	Major: Establish IM&T working group	Mon 02/06/14	Mon
54	Major: Key Decision - Online assessments	Mon 22/09/14	Mon
55	Major: Completion of IM&T project workpackages for delivery of IM&T project requirements	Fri 26/09/14	Fri
56	Task: Collect Business Requirements for new/revised service models	Mon 29/09/14	Fri
57	Task: IM&T System Design	Mon 22/12/14	Fri
58	Task: Implementation of IM&T systems	Mon 16/03/15	Fri
59	Major: IM&T project work completed	Fri 05/06/15	Fri
60	**CIS**	**Mon 10/11/14**	**Mon**
61	Major: Identify all CIS reconfiguration.	Mon 10/11/14	Mon
62	Task: Undertake CIS reconfiguration	Tue 11/11/14	Mon
63	**Financial and Metrics Analysis Workstream**	**Wed 23/10/13**	**Mon**
64	Major: Establish finance and metrics working group	Fri 01/11/13	Fri
65	Obtain Surrey Model	Wed 23/10/13	Fri
66	Assessment of the Surrey Model	Fri 15/11/13	Thu
67	Completion of initial financial impact	Wed 20/11/13	Tue
68	Major: Baseline finance and metrics signed of by Care Bill Programme Board	Thu 08/05/14	Thu
69	Major: Phase 1 cost of assessments analysis completed	Fri 27/06/14	Fri
70	Major: Phase 2 cost of assessments completed	Mon 14/07/14	Fri
71	Major: Identify the resource to work with private sector to identify self funders	Mon 30/06/14	Mon

SCHEME NAME :- Workforce	
SCHEME NO	**21**
RESPONSIBLE GROUP	**Workforce Group**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

The city has a clear and stated aim to move activity and demand away from urgent and emergency care into the community. As patients move to different places in the system, staff will need to move with them. The city needs to have a focussed recruitment, retention and re-training strategy in place, so that staff can be deployed in city where they are needed most.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The need to tackle workforce development is clearly documented when it comes to transformational change to bring about truly integrated care and shape the health and care landscape to be fit for the future - http://www.cfwi.org.uk/. This is also evidenced by the integration pioneers – it is a key work stream for Pioneers and support partners to address collaboratively. There is a limited evidence base for how best to go about making these changes, so this scheme will contribute to growing this and examine what is already in existence.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Workforce development is an enabling group of Leeds' transformation programme.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this*

proposal?

- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Workforce are key to the transformation work being undertaken across Leeds. This scheme is focused at looking at a holistic view and a planned and coordinated view to workforce changes.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£80k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

April 2016 – workforce development strategy agreed and published
April 2017 onwards – roll out of strategy implementation
April 2021 – work underway to understand this in line with broader transformation programme.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*

- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The workforce development group of the Transformation Programme is established and will oversee this piece of work. Key processes include:
- setting out the scope of the project
- evaluating the existing evidence base
- working with the Leeds Pioneer programme to link in with Health Education England, Skills for Care and Skills for Health
- Leeds approach and strategy developed

Exact project plan details still in development.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

These will be managed through the Workforce Transformation Group
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2016 – workforce development strategy agreed and published April 2017 onwards – roll out of strategy implementation April 2021 – work underway to understand this in line with broader transformation programme.

Labour Councillor Lisa Mulherin, Executive Member for Health & Wellbeing
Civic Hall
Leeds
LS1 1UR

Contact
Civic Tel 0113 247 6922
Civic Fax 0113 247 4046
Home Tel 0113 294 5627
lisa.mulherin@leeds.gov.uk
Your ref
Our ref LM/NY
Date 19th September 2014

Dear Mr Kealey

Please find enclosed the latest Better Care Fund submission from Leeds.

The submission of the Leeds BCF plan today marks another significant milestone in our continued joint working between the Health Community and Local Authority in the city. It represents significant combined and united effort to prepare a plan to deliver one of the most difficult government policy initiatives in recent times. The austerity measures required of public services are testing the resilience of all communities and it is heartening to see that our resolve to be the best city for health and wellbeing, and Pioneers in integrating the delivery of our services, is the foundation of the plan we submitted.

We will continue to work very closely with all partners across the City over the coming months to further develop and reinforce our schemes and governance structures to ensure that we are in the best place to successfully deliver the plans attached.

I am aware that completion of the BCF has required significant endeavour by officers of all our organisations who are to be congratulated for their persistence and resilience. The delivery of the plan and remaining tasks will continue to require all our commitment and support.

Yours sincerely

Councillor Lisa Mulherin
Executive Member for Health & Wellbeing

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THE LEEDS £ PLAN ON A PAGE

VISION: Leeds will be a healthy and caring city for all ages

Our ambition to achieve this within our significantly reduced financial envelope is:

A Sustainable and High Quality Health and Social Care System

in which the outcomes of the Joint Health and Wellbeing Strategy are met, and people who are the poorest, will improve their health the fastest:

People will live longer and have healthier lives	People will lead full, active and independent lives	People will enjoy the best possible quality of life	People are involved in decision made about them	People will live in healthy and sustainable communities

We will do this by making best use of our collective resources:

The 'Leeds £' is spent wisely through...

A Commissioning Strategy via the Integrated Commissioning Executive with a Services Strategy via the Transformation Programme Board

In which we can harness and deliver the following 5 national strategic drivers:

Better Care Fund	Care Act	Call to Action	Children & Families Act	Health Innovation

Underpinned by the Integrated Health and Social Care Pioneers programme which enables us to go 'further and faster' through new freedoms and flexibilities

And under the leadership of the Health and Wellbeing Board...
Leeds will be the Best City for Health and Wellbeing in the UK

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A ‘best city’ approach to health and care services - organisations working as one

As leaders of organisations across the city, we have come together to set an ambition to create a sustainable, high quality health and social care system.

We want to ensure that services in Leeds can continue to provide high quality support that meets or exceeds the expectations of children, young people and adults across the city; the patients and carers of today and tomorrow.

We know that we will only meet the needs of individuals and our population if health and social care workers and their organisations work together in partnership.

We understand that the needs of patients and citizens are changing; the way in which people want to receive care is changing, and that people expect more flexible approaches that fit in with their lives and families.

Front line staff, leaders and managers across organisations are coming together in many ways. We are working closely with the voluntary, faith and charitable organisations, universities and investors to act as one; as if we were a virtual ‘single organisation’ to improve the health and wellbeing of the people who live or use services in Leeds.

To do this we have agreed to work together in four ways:

1. Work with patients, carers, young people and families to enable them to take more control of their own health and care needs.
2. Provide high quality services in the right place, backed by excellent research, innovation and technology - including more support at home and in the community, and using hospitals for specialised care.
3. Remove barriers to make team working across organisations and professional groups the norm so that people receive seamless integrated support.
4. Use the Leeds £, our money and other resources, wisely for the good of the people we serve in a way in which also balances the books for the city.

This will be how we improve health and care services for people in Leeds and we are committed to working together to make Leeds the Best City in the UK for Health and Wellbeing.

Tom Riordan
Chief Executive
Leeds City Council

Chris Butler
Chief Executive
Leeds and York Partnership
NHS Foundation Trust

Julian Hartley
Chief Executive
Leeds Teaching Hospitals
NHS Trust

Bryan Machin
Interim Chief Executive
Leeds Community Healthcare
NHS Trust

Andy Harris
Clinical Chief Officer
Leeds South and East
Clinical Commissioning Group

Nigel Gray
Chief Officer
Leeds North Clinical
Commissioning Group

Phil Corrigan
Chief Officer
Leeds West Clinical
Commissioning Group

...working closely with national NHS organisations, patients, their families, carers and the voluntary sector in Leeds.

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Integrated health and Social Care in Leeds – The Outcomes Framework (developed by The University of Birmingham and Social Care Institute for Excellence)

	Better	Simpler	Better value
Service user and carer	I have choice and control over the services I get. Services see and treat me as an individual. I feel there is time for staff to listen to me.	Teams share information (with my consent), so I don't have to tell my story to too many different people. I know who go to if I need to discuss my support. I am seen in hospital swiftly if that's the best place for me	Formal services help me to make good use of everyday, community services and support. I can get the support I need to manage my own condition.
Staff	Service users receive a more holistic response because we're integrated. Integration enables us to use planning and meeting time more effectively. We are able to take a more preventative approach to support.	I can spend more time with users and carers because we're integrated. I am clear about my role and responsibilities and how they fit with other roles in the whole system.	There is less duplication because we're integrated. Processes (assessment, recording and review) are streamlined and transparent. We have clear ways of sharing learning and best practice between teams.
System	Integrated teams have led to improved health and well-being. Information flow between teams and to and from the wider system (Third sector) is better.	Integrated teams have led to shorter times from referral to response. There is a shared care plan across all relevant partners.	Integrated teams have helped people stay at home (and not go into hospital or care homes). There is flexibility in roles (for simple tasks) within neighbourhood teams and the wider system.

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Healthwatch Leeds - Sense Check - Better Care Fund

Key Findings

Overall the areas chosen were supported. Ones that particularly resonated with respondents were:

- Eldercare Facilitators
- Enhancing Integrated Neighbourhood Teams
- Mainstream Winter Initiatives
- Frequent Flyers

Key issues worth considering include:

Dementia - wherever possible services should be provided at home or in the community rather than hospital. The BME focus group felt that there should be a greater focus on awareness raising in communities - this could help diagnosis rates.

Technology - it is important to take a balanced approach here, increased use of technology should not be at the expense of less person to person contact. Concerns about the ethical use and protection of personal information should be taken into account.

Falls - investing in the Falls Service is important, as it can help with quicker hospital discharges and build people's confidence back up in their homes and communities if the correct measures are put in place. It was suggested that the third sector could help with this.

Integrated Community Care Beds - considered to be of the utmost importance, particularly with regard to end of life care, dignity and respect.

Winter Initiatives - Not many of the participants were aware of 2013's Winter Initiatives, and felt that in future they should be publicised in GP Surgeries more.

Seven Day Services - this approach was viewed positively.

Research - this was seen as important and useful.

Quality Standards - some expressed a view that it would be useful to consider whether some existing services (such as Primary Care) should already be providing a high quality service - without need for support from the Better Care Fund.

What we did

The very short timescale prior to submission of the Better Care Fund proposal has meant that Healthwatch Leeds has not been able to formally consult on this bid, but has instead used its networks to take soundings from members of the public.

For pragmatic reasons Healthwatch Leeds has focussed on the Pump Priming element of the Invest to Save Scheme - which has a value of approximately £16m.

The Better Care Fund aims to reduce avoidable hospital and care home admissions, reducing re-admissions and facilitating discharge. To this end Healthwatch Leeds focussed on seeking views from members of the public who had a personal interest or experience in this agenda.

Healthwatch Leeds addressed this in two ways.

- Surveys were sent out to Healthwatch Leeds members by post to give them the opportunity to read through the survey and get an understanding of it. Telephone interviews then took place with 61 members, each lasting around 45 minutes. People were asked to rate the importance of each initiative and provide comments.

- Second, 3 focus groups were held - involving 29 members of the public. One of these groups was targeted specifically at Black and Minority Ethnic communities in Leeds. The other two focus groups involved a variety of participants of differing ages living with different health conditions. Further equality monitoring information is available upon request.

Findings from surveys

Results from the survey 'sense check' is that all areas identified in the Invest to Save scheme were considered to be important. Combining responses for "Very Important" and "Fairly Important" all proposals had approval ratings of between 69% and 93%. Those that had the greatest support were:

- Eldercare facilitators
- Enhancing Integrated Neighbourhood Teams
- Mainstream Winter Initiatives
- Frequent Flyers

Summary of survey results - sample size 61

Initiative	Respondents stating 'very important'	Fairly Important	Percentage positive (very important plus fairly important)
Eldercare Facilitators	38	18	92
Enhancing Integrated Neighbourhood Teams	37	20	93
Mainstream Winter Initiatives – Including a Move to Seven Day Working	37	20	93
Frequent Flyers – A Multi-agency Approach	37	20	93
Expanding the Community Intermediate Care Beds Scheme	34	18	85
Medication Prompting – Dementia	33	18	84

Initiative	Respondents stating 'very important'	Fairly Important	Percentage positive (very important plus fairly important)
Workforce Planning and Development	31	15	75
Primary Care Proactive Management	31	16	77
Enhancing Primary Care	30	23	87
Falls Service	25	23	79
Improving System Intelligence	24	18	69
Information Technology	22	23	74
Ambulance Services	20	24	72

Comments from the survey and focus groups

Enhancing Primary Care

- The general consensus from the survey responses was that it is very important to offer additional support to vulnerable patients, as they need it the most and don't always know how to ask for it themselves. There were however some points questioning how these patients would be identified, and why weren't GPs doing this anyway.
- Focus groups, while the majority of participants considered this initiative to be important because of the significant role of the GP as a first point of contact, able to identify and help vulnerable patients. However, a significant minority felt that it was more important to invest in other front line members of staff who do meet this need in the community.

Eldercare Facilitators

- The majority of survey respondents felt that dementia care is very important, especially as people are living longer. It was also suggested that people would respond better to treatment and testing in a familiar environment (home/GP surgery), as opposed to a hospital. The qualifications of the Eldercare Facilitators were questioned, as their ability to work with these two groups was considered to be very important. In the survey responses a lot of emphasis was placed on dementia, not mental health.
- Out of the focus groups, the majority of participants considered this initiative to be important. Some of the views expressed included:

- a preference for dementia testing/treatment in the GP surgery/home rather than in a hospital, as elderly people can find the hospital environment to be very intimidating.
- a need for more understanding within communities about dementia - this view came from the BME focus group. There was also a minority view that there were already enough people working in this field.

Medication Prompting – Dementia

- The majority of survey respondents felt that ensuring patients who are living with dementia are taking their medication correctly is very important. Some expressed concerns about the costs of community nurses, and wondered whether better use of technology or collaboration with other organisations might be more cost effective.
- The majority of focus group participants considered this initiative to be important. Some were surprised that more use was not being made of Telecare. It was noted that the limitations of technological approaches need to be clearly understood - for example technology was felt to be less effect at monitoring whether people have actually taken their medication. Some participants felt that funding might be better invested in raising awareness of dementia.

Primary Care Proactive Management

- Generally respondents felt that the initiative is a good idea, particularly if it has worked elsewhere. They did however have concerns about people being able to actually use the technology, the resources that may have to go into training them to use it and also the cost of the technology.
- The majority of focus group respondents supported this proposal. Some were aware that this has worked well elsewhere. There were concerns that this should not replace human interaction which elderly people do value. It will be important to ensure that elderly people do not feel anxious and isolated.

Investing in the Falls Service

- The general consensus of the survey responses was that the initiative is very important, as elderly people can often feel very vulnerable after having a fall. Also adaptations being made at home will make for a quicker discharge from hospital which is better for the patient and the hospital. Adaptations and actually spending time with the patient to build their confidence back up will also contribute to preventing falls the future.

- The majority of participants considered this proposal to be important and suggested that the third sector has a significant contribution to make, and highlighted the importance of assessing people's homes to facilitate safe and effective discharge.
- A minority of participants did not consider this initiative to be as important as the others, we have not captured their rationale for this. However, it may be because they are not fully aware of the work of the Falls Service.

Investing in Expanding the Community Intermediate Care Beds Scheme

- There was a very strong consensus from the survey responses saying that the initiative is very important, as people can be kept in hospitals for too long which can be detrimental to their health and is costly for the hospital.
- The majority of participants considered it to be very important and made very strong points about the importance of this initiative in terms of dignity and care, in particular end of life care.
- A minority of participants did not consider this initiative to be as important as the others, we have not captured their rationale for this.

Investing in Enhancing Integrated Neighbourhood Teams

- The survey responses show that respondents consider this to be a very important initiative, as at present discharge from hospital can be problematic for people, in particular for those who are vulnerable and going into an empty home. There are also problems when people are discharged late at night and at weekends, as the staff aren't there to support this.
- All focus group participants considered the initiative to be very important. Rehabilitative care in the community was felt to be very important in aiding people's recovery. However, social and health care teams will need to work together to ensure that this is a smooth discharge for people and an Equipment Service that was open for 7 days a week would aid people's discharge at weekends.

Investing in Mainstreaming Winter Initiatives – Including a Move to Seven Day Working

- Seven day working was supported. There was however some confusion around Winter Initiatives, as people hadn't seen many this year as the weather hadn't been too bad in comparison to past years. Having said that, there was an acknowledgement to how difficult winter can be for vulnerable people.

- Out of the focus groups, the majority of participants considered the initiative to be very important. They noted that they hadn't seen any Winter Initiatives in their GP Surgeries, so they felt that GPs need to be supporting the initiatives more.

Investing in Frequent Flyers – a Multi-agency Approach

- The general consensus from the survey responses was that this is an important initiative, as it is preventative as opposed to curative. However, as with the first initiative about GPs identifying the top 2%, it should be done as a standard. It was also expressed that health and social care services would have to work well together to ensure that adequate care plans are put in place. Several respondents didn't like the term, 'frequent flyers'.
- All focus groups considered the initiative to be very important. All the participants said that this should be done anyway to help drive hospital admittances down. However, there were concerns about minority groups who may not be registered with GPs, such as the Gypsy and Traveller community.

Investing in Ambulance Services

- There was not a clear consensus from the survey response, as respondents found the question hard to understand. Those that did said that services could be provided in the community (particularly testing) rather than having to use patient transport to get patients to and from their appointments.
- As with the survey the focus group discussions did not provide a clear consensus. Some participants felt that people don't always need to access A&E they need to know where to go and for this to be clearly signposted within the community. Others felt that patient transport is often late, but the service does exist already so therefore requires less developmental focus. A significant minority felt that the existing service was good and didn't need any improvements.

Investing in Information Technology

- The majority of survey respondents felt positively about this proposal - particularly because it should lead to more joined up work between health and social care services, which would lead to the better provision of services particularly when people are discharged from hospital. Several respondents also suggested this information be shared with the third sector, as this would help ensure more joined up care.
- Focus group discussion was mixed. Those who considered it to be very important said that if the initiative encourages better joint-up working between health and social care services then it is of the utmost importance, as it will ensure better care is provided when patients are discharged from hospital. Participants who

rated this less highly had concerns about data protection both with regard to personal information being shared and it being lost.

Investing in Improving System Intelligence

- Survey respondents were supportive - recognising the importance of research to improving services.
- The majority of participants felt this was an important area - noting that research could help identify the causes of admission and therefore help prevent unnecessary admission. This would also help good practice to be shared with others.

Investing in Workforce Planning and Development

- Survey respondents felt that it is very important for staff to be trained in the fields that they are working. However, it is not just about training but values and attitudes of staff towards patients.
- The majority of focus group participants supported this initiative - noting that staff need to be trained so that they can do their jobs in the community.

Healthwatch Leeds

If you would like to discuss this report contact Jean Morgan, Acting Director of Healthwatch Leeds.

Telephone 0113 898 0035

info@healthwatchleeds.co.uk

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Patricia and Community Matron Anne Williams

Patricia's story: 'Now I feel more confident going out and safer at home.'

Patricia, 78, from Gledhow has type 1 diabetes, which she controls by taking insulin. She was diagnosed with MS when she was very young. Patricia started falling frequently, and because of this, lost confidence to go out, becoming increasingly isolated. In the 12 months before the Meanwood neighbourhood team became involved, Patricia had been in hospital three times, two of those involving trips to A&E.

Patricia was identified as being at risk of needing higher levels of support in the future, through the risk stratification process. She was one of five patients discussed at a multi-disciplinary team meeting in August 2012 in Meanwood.

> My doctor explained that they're trying to help people like me avoid having to go into hospital if they don't need to. I said, 'Good! I dread going back into hospital.'

'My doctor asked if someone could come to see me,' says Patricia. 'He explained that they're trying to help people like me avoid having to go to hospital if they don't need to, and there might be other things that could help me feel better.

'I said, "Good, because I dread going back into hospital." I find hospitals very stressful places. I know the staff do a good job but if I go in there I don't feel as though I'll come back out!'

A community matron and social worker from Meanwood neighbourhood team then made a joint visit to Patricia's home to talk to her and assess her needs.

'Matron Anne and Jason (the social worker) were both marvellous. Jason realised I needed more help and he referred me to the community falls service. I've since had physiotherapy, which was very helpful too. They've arranged for me to have alarms in case I fall, and a pendant alarm which I wear all day when I'm in the house.'

'I'd advise anybody in my position to have this kind of equipment; I do feel much safer now.'

Patricia was also advised on claiming for attendance allowance to help her to get out more, and received information about local neighbourhood network scheme Community Action for Roundhay Elderly.

‘I went to the group in Roundhay for a while. Before going there I wasn’t going out at all, so it was lovely to have somewhere to go. I’ve since decided that group isn’t for me, but it has sparked an interest in getting out, seeing people and making friends. I do have more confidence to go out and am looking at joining other things.

‘Occasionally I take the bus out to Wetherby and it’s a lovely ride through the villages. I go on a Thursday as it’s market day. And I now feel able to go shopping at the supermarket, taking the bus down and a taxi back.

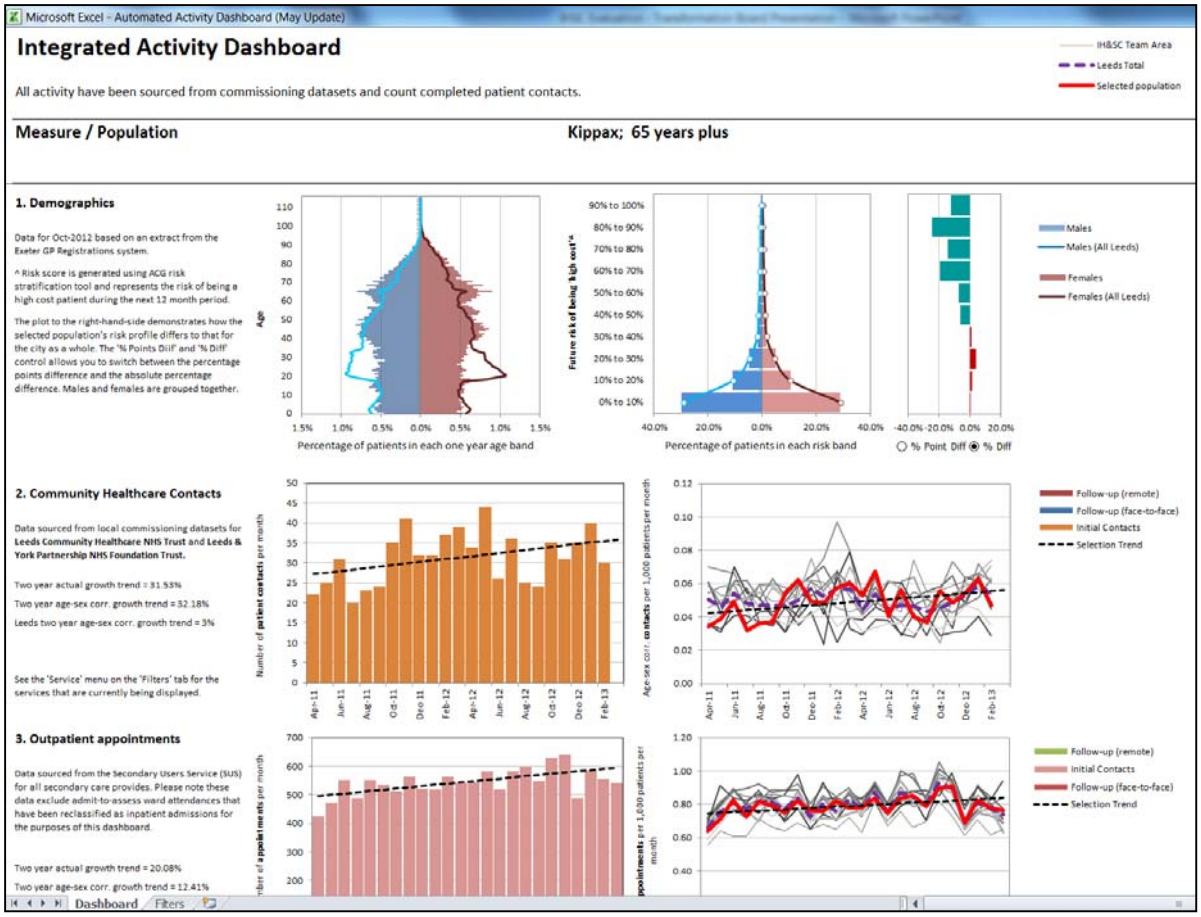
‘Obviously I feel frustrated sometimes because I can’t do as much as I used to when I was younger. When I’m tired I get wobbly and my balance is not good. But I do feel more confident now about getting out with my stick, so I’m in a much better position than when I wasn’t going out at all.’

Patricia is still receiving support from the community matron. ‘I feel good knowing I have a clear link into the health services in Anne,’ she says. ‘She’s such a godsend.’

At the time of writing, Patricia has needed no further hospital admissions and has had far less contact with her GP.

For further information about integrated health and social care for adults in Leeds, email healthandsocialcare@leeds.gov.uk or visit www.leeds.gov.uk/transform.

APPENDIX 12



The Integrated Activity Dashboard pulls together activity data from across health and social care system to enable tracking of changes over time. The dashboard is interactive, enabling data to be seen at individual practice, neighbourhood team, CCG or citywide levels. Data can be filtered e.g. by age group, activity type and specialty to better understand the drivers of change. The dashboard incorporates data on:

- Demographics
- Risk of future resource usage (as derived from the ACG risk stratification system)
- Community healthcare
- Mental health
- Secondary care (outpatients, elective admissions, emergency admissions, length of stay, A&E attendances)
- Adult social care

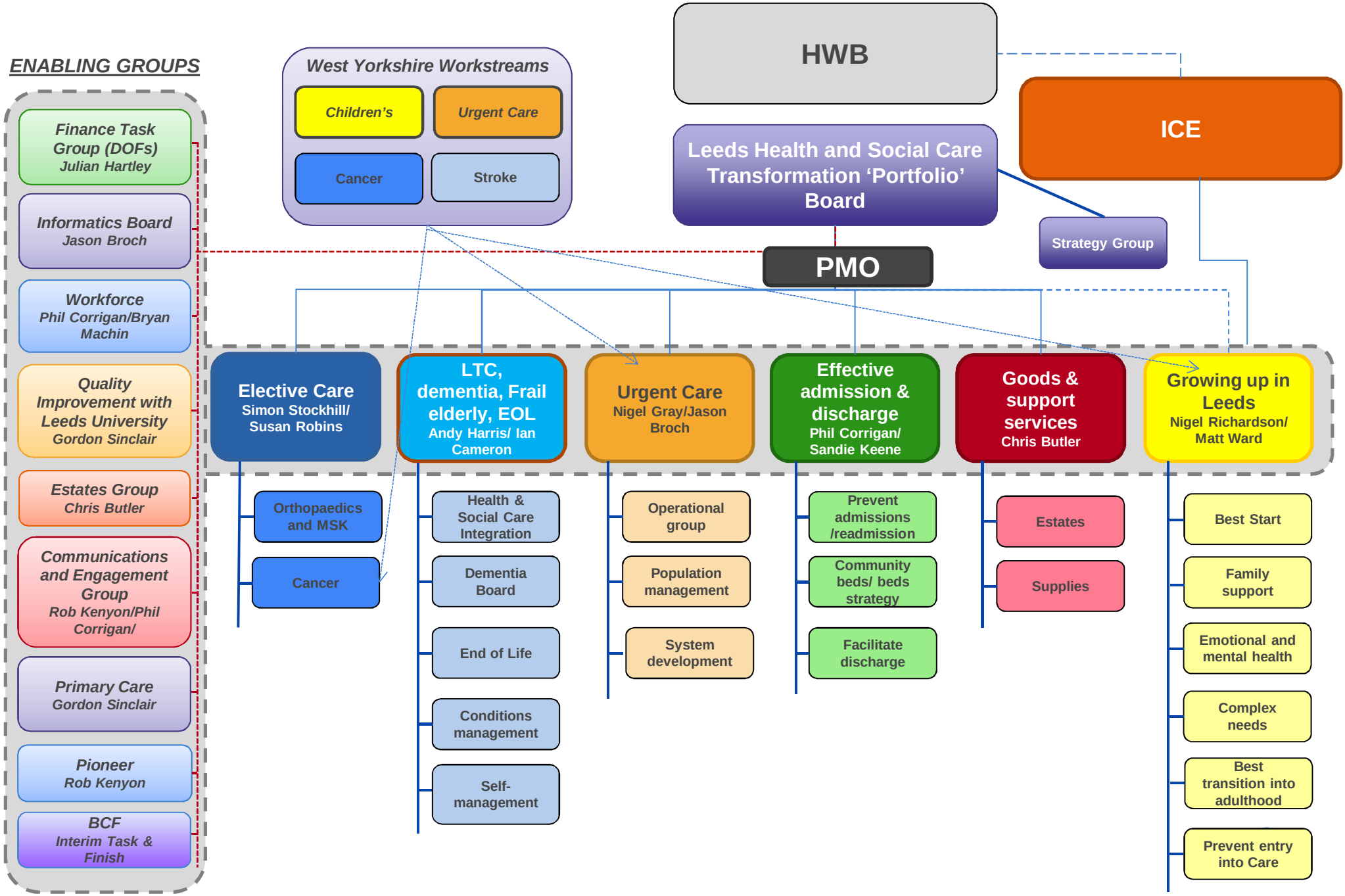
APPENDIX 12

Age-Sex corrected **two** year growth trends

Activity type	Kippax-Garforth		Meanwood		Pudsey		Leeds Total	
Community initial contacts (Core IH&SC team)	6.1%	High	5.1%	Low	13.5%	Ave.	9.5%	
Community initial contacts (Speciality nursing services)	55.1%	High	21.8%	Ave.	28.6%	High	33.8%	
Outpatient first appointments	12.4%	Ave.	9.9%	Ave.	10.3%	Low	9.1%	
Elective inpatient admissions (inc. day cases)	10.7%	High	11.7%	Low	20.4%	High	8.2%	
Total bed days used for elective admissions	-10.6%	Ave.	-18.2%	Low	-47.7%	Low	-30.6%	
Unplanned A&E attendances	5.4%	Low	-1.6%	Ave.	1.8%	Ave.	4.2%	
Emergency inpatient admissions	10.8%	Low	-0.9%	Low	-1.9%	Ave.	2.9%	
Total bed days used for emergency admissions	-5.7%	Ave.	-5.7%	Low	-8.1%	Low	-4.9%	

This table depicts a high level performance report, using data drawn from the integrated dashboard – comparing three of our neighbourhoods. For each neighbourhood, three measures are reported per service as follows: (Column 1) the age-sex corrected % growth rate for the last two years, (Column 2) an arrow showing the trend direction (up or down), and (Column 3) an indication of the neighbourhood's current access rate relative to the 11 other neighbourhoods (high means the neighbourhood has higher access rates than the other neighbourhoods).

TRANSFORMATION PROGRAMMES



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Every Carer Counts

Carers' Strategy for Leeds 2009 to 2012

the Leeds Initiative

the Leeds Initiative

Leeds Multi-Agency Carers' Strategy Implementation Group
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the Leeds Initiative
Local partnerships making things happen

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Foreword

I am very pleased and proud to be able to present the latest Multi-Agency Carers' Strategy which is the outcome of a lot of hard work and consultation. It shows that the City Council, along with our partners in the NHS and Third Sector are really committed to increasing and improving the level and types of support that we can offer to the carers of Leeds. These are our fellow citizens who give up so much of their lives and their time to the care and the quality of life of the person for whom they care. Each year the Carers' Strategy Implementation group will be responsible for overseeing the delivery of our aims through an annual action plan.

In the Health and Social Care world we are all very aware of how much we, and the people being cared for, rely on their unpaid carers. We could not manage the care of adults and children with health or other care needs or disabilities without them. So we are committed to involving carers as partners in decisions on service planning and in the care planning of services for the person for whom they care. I feel that we have developed a good range of support services for carers in Leeds but acknowledge, too, that there is much more that can be done. The continuing increase in carers' grant funding from the Government enables us to expand these services – one example being our Carers' Emergency Plan Scheme which is being expanded and re-launched this year.

I am also pleased to say that the plans we have developed in Leeds fit very closely with the objectives of the Government's ten-year Carers' Strategy announced in June 2008 called *Carers at the Heart of 21st-Century Families and Communities*. That Strategy sets out aims and projects to support carers on a much more diverse range of issues than before, particularly relating to their work life. We look forward to working on these issues with new partner agencies such as the Department for Work and Pensions, JobcentrePlus and Carers' Advice services. The National Strategy also brings additional new funding for the next two years, most of it being directed to the NHS for more carer breaks and we will be collaborating with them and with carers to make sure it is used in ways which meet a carer's greatest need which is usually having a break and a life outside caring.

Sandie Keene
Leeds City Council, Director of Adult Social Services

(Left) A mural created by young carers at the Willow Project representing the life of a young carer

Sandie Keene
Leeds City Council,
Director of Adult Social Services

Chris Outram
Chief Executive of NHS Leeds

Rosemary Archer
Leeds City Council,
Director of Children's Services

Introduction

In June 2008 the Government launched the National Carers' Strategy, *Carers at the Heart of 21st-Century Families and Communities: a caring system on your side, a life of your own.* This is the Government's ambitious ten-year vision that sets out the short and long term agenda for the future care and support of carers. This Strategy is based on the views and concerns of carers themselves. Over the next two years the government will provide an additional £150 million of new funding to Primary Care Trusts to work in partnership with the Local Authority to provide respite care.

The 2006 White Paper on the future provision of Adult Social and Health Care services, *Our Health, Our Care, Our Say*, committed to a 'New Deal for carers' and identified several services and issues which it will prioritise, such as a new national information service, expert carers' programme, and emergency respite services. The Government has accepted that all the ideas and aspirations outlined in *Our Health, Our Care, Our Say* cannot be achieved without new financial resources and has announced further growth in the Carers' Grant from 2008–2011.

With the National Carers' Strategy and 2006 White Paper in mind, Leeds is launching its 4th multi-agency Carers' Strategy – the first one being launched in 1997.

A review of the 2003–2006 Carers' Strategy has revealed gaps which need to be addressed. This

Beeston Action For Families Carers Group

new Strategy document for 2009–2012 and the proposals and priorities within it have come from consultation and listening events with carers during 2005 and 2006. An average of 60–70 carers attended each year. Carers were asked to identify things that helped them and highlight things that could be improved. Workshops have also been held with young carers and parent carers.

This new Carers' Strategy sits within the context of the Leeds Strategic Plan and Local Area Agreement and the NHS Leeds Strategy. These complementary documents identify key priorities for the city that directly impact on people's health and well being and also address the wider determinants of health. Work to deliver these strategic priorities will assist in delivering the aspirations of this Carers' Strategy. At the same time work to deliver the commitments in this Strategy will contribute to the broader objectives for the city.

What is a carer?

A carer is someone who looks after a relative, partner or friend who, because of a mental or physical illness or old age, cannot manage without help. This includes parents or others raising a child who has an impairment. The help they provide is unpaid.

Carers can be of any age and sexuality and are found in all ethnic and faith communities. Carers themselves may be disabled and could be caring in any relationship.

Carers who are providing, or are intending to provide substantial care on a regular basis, are entitled to a carer's assessment and support, and it is the duty of the Local Authority to inform carers of this right. Leeds City Council (LCC) has supported carers' organisations and has itself provided services and direct support to carers for many years. Carers tell us that the existence of a Carers' Centre in Leeds for advice information and support is greatly valued as a core service. This service is jointly commissioned and funded by LCC and NHS Leeds.

Carers' groups will continue to be supported, though they are of interest to a relatively small number of carers. But, as an avenue for peer support and expert information, particularly in the early stages of someone caring or for carers from minority or frequently overlooked groups they have a value. This support can also be provided through courses for carers.

Background demographics

The Census 2001 provides information on carers in Leeds.

- It indicates that there were 70,446 people in Leeds (9.85%) who identified themselves as providing unpaid care. Of these:
  - 14,369 provide 50 hours or more of unpaid care per week
  - 7,631 provide between 20 and 49 hours of unpaid care per week
  - 48,446 provide up to 20 hours of unpaid care per week.
- The census also told us that there were:
  - 1,232 carers aged 0–15 years (1.74%)
  - 52,983 carers aged 16–65 years (75%)
  - 16,215 carers aged 65 years and over (23%).
- People aged 45–60 years are most likely to be carers, as a proportion of the whole population. Of the population over 50 years old in Leeds, 32% provide care at some level. Women outnumber men as carers until after age 75 years when men outnumber women as carers.
- Among carers in the age groups 75 years and over and 85 years and over half of these are providing over 50 hours of care per week. It is known that carers' own health worsens as their age increases. 13% of carers are in full time work.
- Of the 1,232 carers aged under age 16, 68 were providing 50 hours and over of care; and 108 were providing 20–49 hours of care.
- 6.29% of carers are from a Black or ethnic minority community. This percentage is lower than the population as a whole, which may indicate that people from BME community groups do not identify themselves as carers.

Aims of the Carers' Strategy for Leeds

The aim of this Strategy is to ensure that people who choose to care for their relative, partner, friend or neighbour should:

- Be valued for the contribution they make to the quality of life of the person they care for and to the social care economy.
- Be supported in their chosen role.
- Know that the care they provide can be shared with paid workers where that is appropriate and desired.
- Not have to jeopardise their career or other close family relationships through their caring role.

To achieve this, the Strategy will:

1 Acknowledge that all carers are individuals and will be treated with courtesy, respect and dignity having regard to their religious, ethnic, cultural, sexual orientation, disability and age related needs.*

2 Ensure organisations providing support to carers consider their needs alongside, but separate from, the needs of the person for whom they care.

3 Make available independent advice or advocacy for the carer, when difficulties arise for carers in balancing their own needs with the needs of the person cared for or with their relationship with statutory agencies.

4 Listen to carers' views and opinions when planning service changes and when planning care or support services for the person for whom they care.

5 Ensure that all carers know they have a right to a carer's assessment and how to get one, regardless of their background.

6 Have systems in place in statutory health and social care agencies which identify and record carers so that their special needs and circumstances can be addressed, particularly for under-represented groups of carers such as male carers, disabled carers and BME carers.

7 Ensure that wherever possible, carers can get a break from caring through the availability of a range of respite services and opportunities.

8 Empower carers by providing them with good quality information about their rights and local services for them and the person for whom they care. This will be available in a range of languages and formats and will reflect the particular cultural and social issues which affect the speakers of those languages. Effective communication will always have regard to the end users, their experiences and expectations, and recognise that 'one size' cannot 'fit all'. Interpretation services will be provided which have robust quality mechanisms in place.

9 Provide adequate information and training to carers about techniques, equipment and medication for the person they care for, and how to care without damaging their own physical or mental health.

10 Commission services to make sure that appropriate information is available in other non-NHS settings that are accessible to young carers.

11 Provide support to young carers to ensure that the caring tasks they take on do not interfere with their own social, emotional and educational development, and that their welfare is protected as is required under their status as a child in need in the Children Act 2004.

* 'Disabled' includes physical and sensory impairments, learning disabilities, people with long term conditions, mental health needs, many of which increase with age.

Launching an advertising campaign for carers services, Victoria Gardens

12 Find ways to enable carers who wish to combine work and care to do so, and encourage employers to be aware of and adopt HR policies to support the carers in their workforce.

13 Engage and form partnerships with any organisation in the public, community or private sector to highlight the contribution made by carers and take action to assist them in their role.

14 Pay particular attention to identifying and addressing any barriers that carers from BME communities may face in accessing support for themselves as carers and for the person they care for. We will ensure that access and take up of services by these groups is improving and is appropriate to the proportion of their community in the general population.

15 Take fully into account the fact that transport arrangements for the cared for person to access community services and health appointments has an impact on the lives and incomes of their carers. This should be fully taken into account in transport policy (public transport and education, health and social care transport).

16 Ensure that carers in LCC and the NHS Trusts' workforce are supported through flexible working arrangements and leave policy and that they take appropriate action to make staff aware of this support and provide opportunities for carer employees to meet for mutual support.

17 Work with all partners in the Carers' Strategy to establish a scheme among employers in Leeds to promote best practice in supporting carers in the workforce, working in partnership with Chambers of Commerce and other employer organisations in the city.

18 Carry out an ongoing assessment on the effectiveness of this Strategy through monitoring of take-up of assessments and services for carers and take steps to understand and address any under or over representation by particular groups.

19 Carers will have access to services providing advice and information about their benefit entitlement and other financial help, primarily through Carers Leeds and the Leeds City Council Welfare Rights Unit.

Implementation

Some of the above points are generic. Each partner organisation has indicated below how they will implement the points specific to their organisation. Each organisation also has the responsibility for developing, producing and implementing an action plan to ensure that the Strategy is implemented.

Work on these areas will be led by the Carers' Strategy Implementation Group, co-chaired by Adult Social Care and NHS Leeds. It has a membership from a broad range of organisations (including the three NHS Trusts, Carers UK, Carers Leeds, Alzheimer's Society, Leeds City Council, Barnardos and up to ten carers) who are partners in the Strategy. The group draws up and monitors an annual action plan for the implementation of the three-year Strategy.

NHS Leeds through their work plan will:

For all carers

1 Implement a Carers' Charter **(see Appendix 1)** in partnership with other NHS partners in Leeds and Leeds City Council to raise the profile and status of carers.

2 Develop and implement plans, with the Local Authority, for carer breaks utilising new additional monies allocated to NHS Leeds by central government and the existing Carers' Grant to Local Authorities

3 Involve both adult carers and young carers in the treatment plans for the person they care for, particularly where there are learning disabilities, impaired cognition or where discussions and information may appear to be beyond their years.

4 Provide training and resource materials for healthcare staff on carer needs.

5 Designate a lead officer for carers with Director level seniority to act as 'Carer's Champion' within NHS Leeds, who will ensure carers' issues are kept at the top of the agenda and embedded in all NHS Leeds business and in Local Strategic Partnerships.

6 As more care is provided closer to home NHS Leeds will ensure that the needs of adult and young carers are fully addressed through involving them in the development and redesign of all care pathways.

7 Improve the training it provides to carers to assist them in their caring role such as 'Expert Carer' courses; 'Looking after Me', 'Caring with Confidence' and moving and handling courses.

8 Improve access to printed material about health conditions, access to sources of advice and information on treatment, therapies, medication and side-effects.

9 Support GP surgeries to provide appropriate information for carers and display and provide up to date information in its health centres – adult carers have said the best place for information about help for carers to be made available is in GP practices and health centres.

10 Support GP practices to use the 'Yellow Card' scheme to facilitate primary care in referral to the Carers Leeds service and ensure the scheme is adapted for appropriate referral to Willow Young Carers as well.

11 Support GP practices to provide information and involve carers as part of their communication and involvement plans.

12 Work in partnership with GPs throughout Leeds to increase the offer and take up of 'Carers' Health Check'.

13 Continue to commission, in partnership with Adult Social Care, a service to provide carer awareness training to primary care staff, and a support service to carers referred by GPs.

Young carers

1 Raise and promote greater awareness with primary care staff of the need to recognise and respect the important role that some young carers play in the lives and state of health of their parents or siblings.

2 Work with Willow Young Carers Services to make sure that appropriate information is available in other non-NHS settings.

Leeds Teaching Hospitals Trust will:

For all carers

1 Implement the Carer's Charter.

2 Provide a carers' discharge information pack with leaflets on the main carers' support agencies and services in the city.

3 Involve carers in the review of the Trust's discharge policy.

4 Clarify the relationship and respective roles of carers and Leeds Teaching Hospitals Trust (LTHT) staff during in patient stays of people with learning disabilities who are accompanied by a formal or informal carer.

5 Work with other Leeds NHS Trusts, to explore ways of identifying and addressing carers' needs for safe moving and handling training and information.

Parents and others caring for children

1 LTHT staff will meet with parent carers to identify specific problems in the discharge process and develop an action plan that will lead to improvements including the provision of guidance and advice about treatment, medicines and equipment.

2 Take steps to increase the provision of parent accommodation and some areas have already been identified for this within the Trust's estate.

3 The Trust recognises that 'grouped' appointments are beneficial for children and their

parents/carers and will continue to work with parents to meet this need wherever possible whilst acknowledging that this can be particularly difficult to achieve.

Young carers

1 The Trust's Nursing Strategy particularly highlights the need for staff to work in partnership with carers. We will take steps to raise awareness amongst our staff that this means carers of any age and that young carers need to be recognised.

Leeds City Council will:

For all carers

1 Establish a Carers' Hub as one of the components of the new equality assembly, which will be the new equality and diversity involvement and engagement mechanism, which is open to all the people of Leeds.

2 Building on the Carers' Emergency Plan scheme established in 2006, we will use new funding provided by central government to set up schemes which will respond to carers' emergencies by providing or arranging alternative care for the cared for person, in a range of ways. This will be suitable for the carers of children and adults and commence in 2009.

3 Improve out of hours access to social care services and emergency duty social care services.

4 Provide at least three 'Changing Places' style public toilets by 2011. (This refers to a national campaign for public toilets which are equipped to enable older children and adults to be changed in comfort by up to two carers).

5 Continue to improve the access to sport and leisure buildings, swimming pools and individual sport facilities by adults and children with disabilities and their families and carers.

6 More appropriate day activities and residential facilities will be commissioned for people from BME communities with specific language or cultural needs so that their carers may have more short breaks, or for longer-term placements.

Young carers with a display of their artwork at Leeds City Art Gallery

7 As part of the Leeds Disabled People's Housing Strategy, our adaptations service and the Arms Length Management Organisations (ALMOs) will publish detailed literature explaining how adaptations to the home and disabled facilities grants are provided and how Health and Safety and Building Regulations determine what is possible. It will include timescale guidance so that carers can have realistic expectations, and can provide care in their own home safely for themselves and the person for whom they care.

8 Make it a contract requirement that home-based breaks providers give families a rota with named workers in advance.

9 Work to ensure that social care workers have better and more up to date information, materials and training about services and resources for clients so that carers can have confidence in their ability to help them.

10 Inform carers of their right to an assessment and to provide carers' assessments as part of the Local Authority's automatic duty – Adult Social Care has set a target of 30% of carers of adults to receive a carer's assessment by 2011.

11 Communication – the current carers' page on the City Council website will be improved and made interactive. We will continue to produce high quality literature and publicity, regularly revised and available in a wide range of formats and languages which reflects the diversity of Leeds' citizens.

12 Adult Social Care will engage with the further education sector to improve the quality of the support available to students with special needs, and remove barriers to their participation in courses.

13 Extend and promote Direct Payments and Individual Budgets as alternative ways of providing carers' services. We will encourage take up of Direct Payments and Individual Budgets by disabled people through their carers. Specific information on Individual Budgets for carers will be provided.

Parents and others caring for children

1 Parents and carers will be involved in reviewing the existing arrangements for the transition of children with any disability from school and children's social care services to college/ community and adult social care services, and ensure that in the process the carers receive information and guidance from specialist transition workers.

2 We will work in partnership with parents to address their issues regarding the provision of education in schools, special educational needs assessments and therapy services. We will provide support and advocacy to parents in having their voices heard by schools and education services, through our Parent Partnership Service, and the Director of Children's Services Unit. Parents want more independent advocacy.

3 Using the opportunity provided by *Aiming High for Disabled Children*, we will increase and improve the availability of out-of-school child care, holiday playschemes, play and leisure

Young carers celebrate Carers Week 2008 at Leeds Art Gallery

for children with disabilities as a way of giving carers a short break.

4 We will continue to promote and increase the number of parent carers who use direct payments for social care services to meet their children's needs.

5 Improve communication of information about services and involvement in service development and change by establishing a regular, termly newsletter for parents of children with special needs.

6 Establish a 'core offer' of health and social care support and services for families of children who are ill or have disabilities, including regular breaks.

7 Increase the range and availability of short breaks for parent carers.

8 Through our Family Support Parenting strategy, we are committed to increasing the participation of parents and carers, and working with them to achieve the best possible outcomes for their children.

Young carers

1 Leeds City Council will ensure that Adult Social Care services and Children's Social Care services improve liaisons during the period when young carer becomes 18 and can no longer access the Young Carers' Service. Priority will be given to ensuring that the young carer is able to take up further education and training opportunities to ensure their future. The Willow Young Carers' Service and the Adult Carers' Support Services will also collaborate to assist in this process.

2 Work with Willow Young Carers to make sure that appropriate information is available in other settings used by young carers.

Leeds Partnerships Foundation Trust

We provide services to over 520,00 people who are experiencing mental distress or have a learning disability. Whilst most of these people live within the metropolitan boundaries of Leeds, some of our specialist services accept referrals from across the UK. We operate from 48 sites and provide help for over 2,000 people every day.

We value the massive contribution that carers make in supporting the people they care for and as an organisation; we in turn will support carers by ensuring that:

1 We will implement a Carers' Charter in partnership with other NHS partners in Leeds and Leeds City Council to raise the profile and status of carers. This will be supported at the highest level by our organisation. We provide a wide range of information for carers. A Carers' Handbook has been developed and is available for all carers who are referred to our service. The Carers' Support Team are developing an increasing range of leaflets including an information sheet with key contact numbers. These will be available on the Trust's website.

2 The new website will contain a 'Carers' Page' offering support, information and key telephone numbers to carers.

3 Through NHS Direct and Dial House, we will, where appropriate, provide support for carers who find themselves in crisis. Carers of service users who are accessing our services either as in-patients, through acute day services, or via the crisis resolution and home treatment team will have 24-hour access to a mental health professional, via the ward staff or the 24-hour helpline. The crisis resolution and home treatment team make crisis referrals regarding carers who need support to either the appropriate care co-ordinator, or to the Carers' Support Team.

4 We will develop our new data system PARIS across the whole of the Trust so that we can collect accurate data about carers and which in turn will enable us to shape our services appropriately.

5 We work towards reducing the differential of services available to carers of older people. We will scope what is currently provided, and seek ways to expand our support services to address the imbalance for people over 65.

Carers explore their experiences with each other at Carers Leeds

6 Carers' Connections will provide a wide range of education programmes to support carers in their role. These courses can be accessed by individual carers through a self referral or via the Carers' Support Team. The courses cover many issues around mental health problems, medication and treatment, mental health legislation, helping carers to manage their own health.

7 Carers are welcomed and included in care programme meetings, and care co-ordinators are encouraged to seek out the views of carers. Where the service user is in agreement carers are consulted with and valued as an important part of the care team. Carers will be included and supported where appropriate through the care programme of the person for whom they care. Carers' needs and contributions will be captured within the care plan, and supported by the care co-ordinator.

8 Carers' own needs will be assessed and supported as appropriate, the care co-ordinator or carers' worker will provide support and information about respite, self-care, and access to further information. This can also be found on the Trust web site.

9 The Carers' Support Team will support carers in communicating with mental health professionals where family members feel they are not being heard or understood. Whilst not able to provide an independent Advocacy role they will advocate on behalf of the carer. The PALS service is also available to support carers through issues where they needed support.

10 As an organisation we will ensure that carers are able to make a significant contribution to the welfare of the person they care for, they are included in training, involvement opportunities, recruitment and selection, and consultations around service re-design. This is a core standard of our Involving People Policy.

11 The Carers' Support Team along with the practice development staff will provide specialist training for the police force, around the care and responsibility of people with mental health problems.

12 Carers' support groups are run both in the community, facilitated by carer support workers, and by health care professionals within specific services such as: learning disabilities, older peoples' services, dementia services, eating disorders, chronic fatigues. These groups exist purely to support people in their specific caring roles, and facilitate peer support between carers.

Glossary

ASC	Adult Social Care
BME	Black and Minority Ethnic
CAF	Common Assessment Framework
CPA	Care Programme Approach
DASS	Director of Adult Social Services
DCS	Director of Children's Services
DLA	Disability Living Allowance
EDT	Emergency Duty Teams
LCC	Leeds City Council
LPFT	Leeds Partnerships Foundation Trust
LTHT	Leeds Teaching Hospitals Trust
SEN	Special Educational Needs
SENCO	Special Educational Needs Co-ordinators
SILCS	Specialist Inclusive Learning Centres

Drama group for carers held at Touchstone Support Centre (a MEMHO project)

APPENDIX Leeds Carers Charter

Leeds Carers Charter

A carer is **a person who provides care for someone else who, because of long term illness, mental illness, impairment or old age, is not able to care for him or herself.**

A carer can be:

- *A parent*
- *A son or daughter*
- *A brother or sister*
- *A husband, wife or partner*
- *A relative, friend or neighbour*

A carer is someone who is not paid for the care they provide.

Young carers are children and young people who take or share responsibility for the care of another person (Carers Act 1995).

If you are a carer, using our services, you can expect:

- *To be recognised, identified and valued for your caring role and be treated with dignity and respect.*
- *To access, or be signposted to, relevant and up to date information about the support that is available for you as a carer.*
- *Our staff to inform you about the right to a carer's assessment and to be referred appropriately - if you wish.*
- *Your own health needs to be recognised and to be supported to maintain your physical, mental and emotional health and well-being.*
- *To be included (with the permission of the person you care for) as a valued partner in the planning and delivery of his/her treatment and care, and in particular in discharge planning.*
- *To have the right to choose the level of care you are able to offer, depending on your age and ability.*
- *To be considered as an individual, and for services to strive to reflect your own needs.*
- *Have opportunities to comment on, and be involved in, the wider planning and evaluation of services.*

If you need more information on this charter please contact:

NHS Leeds:
0800 0525270 (PALS)

Leeds Teaching Hospital NHS Trust:
0113 206 7168 (PALS)

Leeds Partnerships NHS Foundation Trust (LPFT):
Contact LPFT Carers Support team on **0113 295 4445**

Leeds City Council (LCC):
Services for adults
0113 222 4401
Services for children and young people **0113 222 4403**

NHS Leeds City Council

Working in conjunction with NHS Leeds, The Leeds Teaching Hospitals NHS Trust and Leeds Partnerships NHS Foundation Trust

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Signatories to this Strategy

- Leeds City Council
- Leeds Teaching Hospitals Trust
- NHS Leeds
- Leeds Partnership Foundation Trust
- Age Concern
- Carers Leeds
- Alzheimer's Society
- Carers UK Leeds Branch
- Willow Young Carers – Barnardos

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Website: www.leedsinitiative.org

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Local partnerships making things happen

Young Carers

- The Willows Project 0113 240 8368 can help a young person (and their family) who is affected by a caring situation to cope with problems and get some fun for themselves.

Help in a crisis or emergency

NHS Direct 111 – for medical advice

Carer's Emergency Plan Scheme
(must pre-register) **0303 123 1921**

Emergency services 999

Your GP

The Samaritans 0113 245 6789 or 0345 909090 – a listening ear

Carers Leeds 0113 246 8338
– advice and support

Emergency Duty Social Care Services
0113 240 9536 (out of hours tel number)

There are 2 other leaflets in this series:

Assessment for Carers

Getting a Break

These leaflets are available in large print, Braille and on audiotape as well as in the following languages:
Bengali, Cantonese, Punjabi and Urdu.

There is also a directory available about services for carers in Leeds: Choices for Carers.

To get copies of any of the above, please telephone **0113 247 8630**

Mental health crisis services

Connect Carers Helpline 0808 800 1212
Open 6pm–10.30pm. Emotional help and support for carers and people in distress

Saneline 08457 678000 12 noon–2am

Your own Health Keyworker

Published by Leeds City Council January 2014

Adult Social Care

Caring in Leeds

Quick Guide to Services for Carers

Better Lives | Housing, Care & Support

Do you help to look after a friend, relative or neighbour at home?

There are ways that we can help you

www.leeds.gov.uk/carers

Adult Social Care

Quick Guide to Services for Carers

The 2011 Census showed there are over 71,500 carers in Leeds helping to support an adult or child at home who is a relative, neighbour or friend. Carers make a big contribution to the quality of life of the person they look after, often at the expense of their own mental or physical well-being.

This leaflet gives an outline of the services available to support carers. More details are given in the directory Choices for Carers, and can be found on our website www.leeds.gov.uk/caringinleeds

Are you a carer?

If you give substantial and regular care or support to a person with a long-term illness, disability who is elderly or frail, or who has a substance misuse problem you might need some help.

There are many different types of help available from a range of organisations. However, which organisation you get support from often depends on the health condition and age of the person you are helping.

A Carer's Assessment

Social Care Services can do an assessment of your needs as a carer so that they can help you get the services you need. It doesn't matter whether the person you are helping is using a service from Social Care Services or not. To ask for an assessment call:

Telephone Centre: 0113 222 4401 Carers' of adults
0113 222 4403 Carers' of children

They will pass your details to the right office. Carers of people using mental health services can also get a Carers Needs Assessment by speaking to the mental health service professional involved with the person they care for.

Information, support, advocacy and advice for carers

- **Alzheimer's Society Leeds 0113 231 1727** – information, advice and support group for carers of people with Dementia/Alzheimer's, of any age.
- **Carers Leeds 0113 246 8338** – advice, information, financial help, social events, courses, support from other carers. Email info@carersleeds.org.uk
- **Carers UK Leeds 0113 275 4718**
  National Helpline 0808 808 7777

  Older Carers Support Service
  0113 272 0377 – support service for people over 65 caring for an adult with a learning disability.
- **Mental Health Carer's Support Service**
  0113 295 4445 – support service for carers supporting someone with a mental health problem other than dementia.

Financial & other advice

- **Carers Leeds 0113 246 8338**
- **Citizens Advice Bureau 08701 202450** and local offices.
- **Leeds City Council Welfare Rights Unit 0113 214 9006**

Planning for your emergencies

- **Carers Emergency Plan** scheme – help if the carer is taken ill – **Claimar 0303 123 1921**. You must be pre-registered to use this scheme.

Short breaks & other respite breaks

- From Adult Social Care after an Assessment
- Family Placement – contact Social Services
- Home Based sitters schemes

  South Leeds area 0113 274 1900

  East Leeds area 0113 223 7321

  North East Leeds area 0113 268 4211

  North West Leeds area 0113 240 4164

  West Leeds area 0113 240 4164

Daytime activities for the person being cared for

- Day Care for older people with physical disabilities – Social Care
- Mental Health Day Services – Leeds City Council or Partnership Foundation Trust
- Daytime support to access community facilities and activities

Help in the Home

- Community support in the home
- Telecare equipment to keep people safe in the home
- Nursing services at home, physiotherapy, chiropody etc. – contact your GP

Charter for Involvement in Integration

The Charter is a clear set of statements by people in Leeds with long-term conditions and carers about our expectations for involvement in Integration. It brings together people's views and needs, making clear what we want from integration and how other people can help achieve this. Changes that follow this statement will support what we want for the future and our lives. Effective Integration in Leeds needs:

- Genuine involvement that is demonstrated by views being heard, not just the opportunity to raise them.
- To adhere to high standards / good practice in involvement, ensuring lots of varied opportunities for people to be involved in a meaningful way, whatever our level of skills / confidence / understanding of the issues.
- To take into account what's already been asked… and answered
- Involvement that reinforces what people find valuable in being involved, that it makes a difference.
- Involvement that includes people with long-term conditions and their family / friends carers, where appropriate separating out different agenda / views.
- Involvement with existing groups / networks so that information can effectively be cascaded by them and views sought from particular groups of people via those networks
- Involvement of voluntary and community sectors supporting older people, and specialist organisations supporting people with a particular long-term condition, but not using this to replace the direct voice of individuals with long-term conditions
- People with long-term conditions involved in every part of the work at every level, with people on Boards acting as a conduit for wider views into the project.
- To recognise the many calls on people's time, developing different ways for people to be involved and avoid duplication / clashes in other involvement activity and commitments / caring responsibilities.
- Feedback from involvement and the opportunity to add more as people think of it
- To model good practice and promote the Dignity agenda to improve standards of care more generally

To make this real, I/we will ……

……

Name: ……Date: …….

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System vision

Success for us is when the people of Leeds:

- live longer and healthier lives.
- live full active and independent lives.
- have a quality of life improved by
- access to quality services.
- are involved in decisions made about them.
- live in healthy and sustainable communities.

Our aim is that Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest.

Sustainability

Through our economic modelling approach we have refined our calculations of the whole system financial challenge and this shows an estimated shortfall of approximately £64.1 million in 15/16 which we expect to rise to £619 million over 5 years.

Governance overview

The Transformation Board has an effective governance structure that ensures that the work of the Board oversees the programmes beneath it. All programmes are led by Senior Directors with cross system membership and all have communications and engagement plans. The Transformation Board also reports into the Health and Wellbeing board.

Involved, included and empowered citizen

We will do this by:

Engagement

- using asset based engagement.
- seeking and using customer insight.
- working with, and through, elected members.
- working through neighbourhood networks

to ensure that health care system changes reflect and meet local need.

Empowerment

- ensuring all individuals and communities have equitable access to ill health prevention activities.
- developing our workforce to have the skills, knowledge and culture to support individuals to self-care.
- effective use of patient decision support tools.
- adopting the principles from the House of Care model

Wider primary care , provided at scale

- Effectively managing clinical risk at an individual and population level.
- Tackling unwarranted variation through collaboration and shared learning.
- General Practice leading integrated out of hospital care to meet the needs of the local population.
- Working with local communities and Primary Care providers to improve access by developing capacity to meet population need.

A step-change in the productivity of elective care

- Using patient decision support to meet individual need.
- Harnessing micro commissioning to meet local need.
- Ensuring care flows for patients with pathways without boundaries.
- Using the latest technology to enable patients to be seen by the right professional at the right time in the right place.

A modern model of integrated care

- Ensuring we understand individuals and populations:
  - who are at risk now and in the future and
  - ensuring they are known to the health and social care system.
- Developing community based service models that are
  - clinically integrated across social, primary, community and secondary care and
  - incorporate the principles of the House of Care model.
- Building trust and understanding between culturally different care workers to ensure effective working with clear accountability.
- Aligning incentives across multiple providers by developing common outcomes, indicators and performance measures.

Access to the highest quality urgent and emergency care

- Providing a planned response to urgent care needs which can be identified in advance and an appropriate and responsive one where they cannot.
- Providing new service responses for the intoxicated.
- Enhancing services for people with mental health needs.
- Providing timely access to urgent primary care for children.

Specialised services concentrated in centres of excellence

The Leeds CCGs and NHS England will join together to ensure that we are able to support LTHT to deliver services as a centre of excellence.

- Working with our providers to develop their specialised services for Leeds with the wider commissioning community.
- Providing system leadership.
- Developing the cancer centre.
- Working to integrate pathways locally and regionally.
- Exploring research opportunities with the universities.

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Health and Social Care Integration Pioneers - Expression of Interest from Leeds

1. Foreword from Councillor Lisa Mulherin, Chair of the Leeds Health & Wellbeing Board

Leeds is a city of innovation, drive and ambition. It has led the Commission on the Future of Local Government. It is a pioneering city with a vision to be the best city in the UK by 2030, which also means being the best city in the UK for health and wellbeing and a Child Friendly City.

Leeds is the third largest city in the UK with a population of around 800,000, expected to rise to 1 million by 2030. It is a modern and diverse city; Black, Asian and Minority Ethnic groups make up almost 18% of the population. 150,000 people live in the most deprived neighbourhoods nationally, with a life expectancy gap of 12.4 years for men and 8.2 years for women. There are 180,000 children and young people, of whom 1367 are currently Looked After Children.

Leeds has a unique health and social care ecosystem and supporting infrastructure, bringing together local and national public, third and private sector leaders and organisations, enabling a coherent strategic voice across Leeds led by the Health & Wellbeing Board. We are committed to working together to spend the 'Leeds pound' wisely on behalf of the people of Leeds, making best use of our collective resources. We already work together to make sure that services are joined up and easier to use. Our Joint Health & Wellbeing Strategy will underpin decisions about spending money and planning services over the next few years to make integrated health and social care the norm in Leeds.

Leeds featured on the national BBC coverage (Elsie's story) of Norman Lamb's call for integration pioneers in May. Focused on improving quality of care for patients and service users, their carers and families, we are creating a culture of cooperation, co-production and coordination between health, social care, public health, other local services and the third sector. We also recognise the potential presented by new technology and shared information to support integrated working, and to give people with long term conditions the ability to self care. We will capitalise on the city's unique assets to go further and faster on this journey to deliver better outcomes for individuals, families, carers and communities as defined in the Leeds Joint Health and Wellbeing Strategy and the Leeds Children and Young People's Plan.

Leeds City Council, the three Leeds Clinical Commissioning Groups, Leeds Community Healthcare Trust, Leeds Teaching Hospitals Trust and Leeds and York Partnership Foundation Trust have joined together, supported by local and national third sector partners including Third Sector Leeds and local user groups, to make this application. It is endorsed by the NHS England Director for West Yorkshire as a member of the Leeds Health & Wellbeing Board. A full list of stakeholders is attached at **Appendix 1.** Together we have lots of great ideas – we want the support to do more and do it more quickly.

As a pioneer, quality of experience for the people of Leeds would be at the heart of our approach across three key strands:

- INNOVATE
- COMMISSION
- DELIVER

Our strategic approach is underpinned by the following key principles:

- Embedding our commitment to public involvement right across the system
- Developing a new social contract with the people of Leeds
- Ensuring a digitally enabled and informed population
- Being clear and transparent in our decision making
- Improving health and reducing inequalities across Leeds

2. Our vision for integrated care and support

Our overarching vision is to improve quality of care and outcomes for people with complex needs by overcoming the fragmentation associated with multiple providers. People in Leeds who use care and support, their families and carers have told us they want:

> Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect.

In Leeds, we identified that a common narrative would help to create a shared purpose and outcomes for integration in health and social care. Our work to develop 'I statements' and design principles for integration enables us to identify 'how we will know when we get there'. Using the needs and wants of people accessing services and their carers to form the principles behind our definition of integrated care helps us to ensure that we make changes that can improve outcomes and experiences for people accessing services, through keeping the voice of the people of Leeds at the heart of everything we do. A fundamental part of our approach is to involve people in all we do, to the extent that we now have a Leeds Charter for Integration **(Appendix 2).**

We fully support the National Voices definition of integrated care and support:

'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me'

It is not surprising to find that our work in Leeds with both adults and children has been incorporated into the National Voices work, enabling us to continue to develop strong 'we statements' that respond to the shared themes.

Our vision for integration, focused on wellbeing, prevention and early intervention, spans the entire health and social care system and age range, from children's through to adult services. This includes integrated services for vulnerable children; and integrated adult neighbourhood health and social care teams focused on GP practice populations, aligned with mental health services in the same neighbourhoods. These teams link to the wealth of third sector organisations and other community assets in these areas (including our unique Neighbourhood Network Schemes), and have a strong interface with acute hospital services. Rather than having a vision focused on structural solutions, our approach is developmental and iterative – focused on finding ways for staff from different organisations and backgrounds to work together with service users, families and carers to find the solutions that best meet their needs and deliver the best experiences, outcomes and use of the collective resource. We will evaluate options for structural solutions as part of our next steps.

We have undertaken a comprehensive baseline study of staff, service user and carer perceptions, with support from the Social Care Institute for Excellence and the University of Birmingham. This led to the co-production of an outcomes framework populated with a series of statements setting out the improvements we hope to achieve through integration. In assigning metrics to the statements **(Appendix 3),** we have aligned our outcomes framework to the national outcomes frameworks and the Leeds Joint Health and Wellbeing Strategy.

We have also widely involved children and young people, and their responses have informed our Children's Strategy. The Growing Up in Leeds survey draws responses from a large school-age cohort and provides population baseline data across a broad range of issues critical to children's perception of their upbringing in Leeds. Children with a disability in Leeds have said that they want more say over their choice of activity, leisure and short breaks:

- Listen to us and talk to us so we understand
- Make us happy – and help us feel safe when we are having fun
- Help us make choices about what activities we do

3. Strand One – Innovate

Innovation to underpin high quality experiences

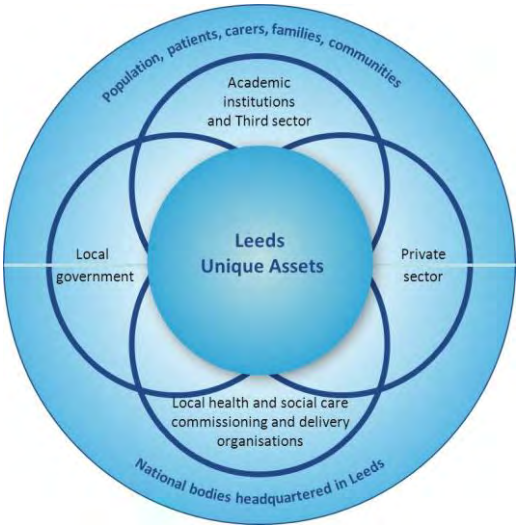
- **Encouraging, enabling and implementing innovative products**
- **Focus on people, processes & technology**
- **Involving communities and public participation**
- **Digitally based approach**
- **Ground breaking work on information governance to support information sharing**
- **Technology to support patient care and self management**

The Leeds health and social care ecosystem has developed over the last 12 months to create Leeds Innovation Health Hub (LIHH) with the objective of making **Leeds First for Health and Innovation.** This signals a game changing approach to health and innovation, brought together by Leeds and Partners, and delivers a theme of 'one voice, one ambition' for the City. The LIHH executive is made up of all constituent parts of the Leeds health and social care system and includes public, private and third sector organisations, with strong links to the Academic Health Science Network. The LIHH is our approach to delivering improved health outcomes based on the NHS Innovation Health and Wealth strategy to *"translate research into practice and develop and implement integrated healthcare services".* The LIHH does this by encouraging, enabling, and implementing innovative products and services at scale and at pace.

In particular, Leeds is harnessing information and technology as significant catalysts for transformation and integration of care services. We believe that our 'digitally' based approach to integrated care will not only deliver improved health outcomes and financial efficiencies but will lead the way to wider integration and transformation of public services as Leeds is on track to become the UK's first fully digitally enabled city. Furthermore, this approach will not only drive forward innovation for the improvement in quality of health and social care, but really add value to the Leeds economy. Our new ways of working have potential to attract inward investment, not only for Leeds as a city, but for the UK as a whole.

Leeds is a big diverse city and has a number of unique assets that differentiate it from other UK core cities:

- a strong 'ecosystem' of collaborating local and national organisations determined to champion an integrated care system focused on prevention, civic enterprise and partnership
- an environment that supports partner organisations to co-produce, develop and deploy innovative care products and services on a large scale – a population of around 800,000, the second largest metropolitan authority in England and one of the largest teaching hospitals in Europe with an annual budget of £1 billion
- ready access to a local network of experts and key enablers - five national NHS bodies based in Leeds, three universities involved in health related teaching, one of the largest bioscience research bases in the UK, and the UK's second financial services centre.



The city's whole system integration plans address three constituent parts of people, processes and technology which all need to come together around the needs and wants of people to achieve high quality care, improved health outcomes and operational efficiencies. Accordingly LIHH is embarking on a work programme, embracing community involvement, partnership and co-production, to accelerate and enhance these evidence based themes:

i. Involving communities and public participation to provide:
   - interaction with my digital care record
   - access to data on the outcomes I should expect
   - patient portals to support self management
   - connections to other people like me and peer support
   - person led innovation and a rights based approach to tackle disabling barriers

ii. Informatics to enable:
- new common standards and information governance to allow appropriate sharing of information across all of health, social care and provider organisations, so that people can receive care from the right person, at the right time, in the right place
- creation of the Leeds Care Record – to become the first major city to deliver an integrated digital care record
- creation of a city 'big data' platform and associated analytical expertise 'institute'
- measurement of Real World Outcomes as new interventions are tested and deployed
- risk stratification and analysis of information to inform potential proactive interventions in people's care, and to plan services for the population
- integrated systems and processes across children's and adults' services to enhance clinical decision support
- integration of information from remote monitoring systems as part of telehealth strategy

iii. Medical technology. Leeds positioning itself at the heart of the largest, most advanced Medical Technology cluster in the UK to:
- enable the use of new technology (telehealth, telecare, telecoaching) in supporting care
- develop smart phone software applications, focused on self management
- support new ways of working with technology for staff to improve efficiency

Leeds will make a strong bid to the recently announced Technology Fund "Safer Wards, Safer Hospitals". We have already provided a patient-safety 'vignette' to support publication of the Technology Fund, based on the recent journey to digitise medical records at the Leeds Teaching Hospital and the planned Leeds Care Record development.

4. Strand Two - Commission

The City Council and NHS organisations in the city spend in excess of £2.5bn on commissioned and provided services for the benefit of the people of Leeds. In establishing the Health and Social Care Transformation Board, leaders in the city recognised the importance of maximising positive outcomes for individuals, introducing the concept of the 'Leeds £' and the principle that much more could be delivered by use of that pound collectively. The Transformation Board also recognise that by streamlining and integrating care pathways, and investing in community based preventative and early intervention services, better outcomes could be delivered for people and the increasing pressure and costs of hospital admissions and long term residential care placements could be significantly relieved or deferred.

Improving quality of experience through better Commissioning
- **Collective use of 'Leeds £'**
- **More early intervention services – less reliance on hospital & long term social care placements**
- **Predictive & financial modelling techniques**
- **Third sector commissioning**
- **Outcomes based approaches**
- **New funding and contracting models**

The achievements to date have been achieved with significant commitment from city leaders, reflected in both the governance arrangements established, and the collective investment and disinvestment of resources across the system, for example:
- Investment of CCGs' 2% non-recurrent funding in whole systems change and system capacity
- Collaborative approach to the Health Funds for Social Care (£11.9m in 2013/14) and the investment of NHS Reablement funds in the city
- Investment in the development of the Leeds Care Record
- Investment in predictive and financial modelling techniques – Risk Stratification, Care Trak – to ensure the 'so what' question can be answered by evidence in terms of outcomes, activity levels and resource impacts
- Joint investment to roll out targeted mental health services in schools (TaMHs) across the city
- Improving the joint commissioning of placements for Looked After Children
- Joint commissioning of a wide range of early intervention and prevention services in the third sector
- Joint commissioning and delivery of a locality based intermediate care facility as a public sector partnership

We firmly believe that to continue to deliver improvements to outcomes for the people of Leeds we require support to overcome national barriers that currently detract from achieving local improvements. Our preferred model would be to develop solutions through the auspices of a public sector partnership within the city. An innovative approach to commissioning will support Leeds to be the best it can for Health and Social Care - including the following key features:

- Fully embedded shared vision for health and social care across Leeds, and common shared values hard wired within each organisation in the city
- Planning of services based on understanding of population need and the evidence base
- A new social contract with the people of Leeds based around Restorative Practice, a problem solving approach characterised by working with people, not doing things to them or for them
- Greater organisational integration where this supports improved outcomes and/or release of resources through efficiencies
- Mutual understanding of commissioner and provider financial plans across health and social care to support joined up investment and dis-investment decisions, better cost anticipation and predictive modelling capability, and new operating and contracting models that support integrated working and deliver significant financial benefits e.g. risk based contracting
- More use of pooled budgets, building on our current joint commissioning arrangements
- Sustained investment strategies focusing on prevention and early intervention
- Significant investment in community based services that support people to live safely and independently - through disinvestment of resources associated with appropriate reductions in hospital admissions, hospital bed days and long term residential placements
- Ability to evidence whole system value for money from all interventions
- All decisions on allocations of funding based upon outcomes for individuals not contractual obligations, and any adverse impacts upon organisational bottom lines addressed through pre-agreed risk and reward mechanisms
- Increased customer satisfaction resulting from fewer professionals delivering care to one individual, seamless pathways of care, relevant information via a shared care record
- Empowered individuals, and where relevant their carers, able to easily access health and social care support in managing their own conditions and needs individually and collectively
- Culture change to enable services to be delivered by a multi-skilled flexible workforce

The Directors of Finance Group (health and social care commissioners and providers) has already embarked on a citywide exercise to determine for the health and social care economy in Leeds:

- What is the total funding available? (The Leeds £ quantum)
- Where it is spent? Who is spending it? And what is it spent on?
- What outcomes is it currently achieving?
- What are the rules and regulations currently governing how it must be spent?

This will establish a baseline for both total spend and expenditure in relation to integrated services, enabling accurate extrapolation of the impact upon both the funding and outcomes of proposed changed ways of working. We have built upon the development of predictive models through Risk Stratification and the Year of Care Tariff, and have developed a unique and innovative capability through the application of a Care Trak solution to draw together and analyse integrated health and social care data, providing valuable baseline data and the ability to measure quantitative impacts resulting from early integration initiatives **(Appendix 4**). This system will enhance our capability to make evidence based whole system decisions on where to prioritise future activity and spending.

5. Strand Three - Deliver

Focused on improving experience and outcomes for the individual, all parts of the Leeds system are already taking collective action to make a real and sustainable change to how health and social care is provided. We have made significant progress already on delivering integrated health and social care services for both children and adults, focused on people's holistic needs and on giving people greater choice and control. Our work has focused initially on older people, those with long term conditions, vulnerable children and families in order to create a system that is focused on the needs of people regardless of their age. We have

found that the main themes are remarkably similar whatever services and user groups are involved. Work done to develop the detail of new delivery models has been specifically focused to children's, young people's and adults' services as described below:

Improving quality of experience through improved Delivery

- **Person centred care, including carers and families**
- **Seamless working between all components of health and social care system**
- **Information sharing with due regard for governance**
- **Transforming the workforce**
- **Reducing duplication**
- **Culture change and organisational development**
- **Supported self management**
- **Proactive identification of caseloads**

Children and Young People

We place children at the heart of everything we do to ensure that Leeds becomes a Child Friendly City. Our ambitious Children and Young People Plan informs our drive for integration. In just three years numbers of children with a need to be in care have reduced by 4%, children absent from school have reduced by 1.4% (primary) and 2.9% (secondary) and the numbers of young people who are NEET have reduced by 30%. We also have secured the overarching principle of working restoratively with children and families (not to or for them but with a high challenge, high support approach) through a whole workforce training strategy.

In two years Leeds has delivered a transformational programme to integrate health visiting and children's centres into a new Early Start Service across 25 local teams in the city. Children and families now experience one service, supporting their health, social care and early educational needs. This service champions the importance of early intervention and giving every child, in every community, the best start in life **(Appendix 5).** The focus has been on the needs of the child and family and activities to support these rather than traditional professional silos. The approach has been integral to Leeds' status as a first wave Early Implementer Site for "Health Visiting: A Call to Action".

This integration from birth sets in place the momentum and expectation of joined up services over every lifetime. We provide the simplicity of a single 'front door' for parents and intend to expand this model further to encompass all vulnerable children across the city, particularly for those with complex needs (health, educational and social) and those at risk of becoming looked after. We also work with colleagues in healthy living and adult services to influence the commissioning of services that support parents with mental health problems or who abuse drugs and/or alcohol. Every opportunity will be taken to eliminate the need for children to have to negotiate numerous gateways into services, or to enter hospital, or indeed care where effective wrap around services could prevent this need.

The strong evidence base for early prevention and intervention in the Allen Review (2011) underpins the Early Start Service, Family Nurse Partnership and our recently jointly commissioned Infant Mental Health Service **(Appendix 6).** We will embed and expand the Early Start offer to further support vulnerable groups, ensuring specialist health and social care services wrap around the needs of the child and family.

We will maximise opportunities for children to remain outside care; integral to this is our strategy to support informal and formal kinship care arrangements wherever possible. This will be based around a whole partnership engagement with a Family Group Conferencing model as the preferred route to restorative conversations with families.

We also aim to transform current Special Educational Needs (SEN) pathways to a single integrated process from maternity, neonatal services through to Early Start and the specialist multi-agency services that support vulnerable children. We will support families as they come to terms with their child having a disability. This will build upon current Early Support practice by Specialist Health Visitors and the Early Start Service. We will integrate broader specialist services with this model to enable the single Education, Health and Care Plan as defined by the Children and Families Act (2013).

Adults

Our progress over the last 18 months is well documented through our video 'Working together to improve Health and Social Care in Leeds'. Our evidence based approach is focused on seeing the whole person, with an emphasis on improving their experiences and outcomes, and supporting people to remain independent, living in their own homes for longer - involving the following dimensions:

- Predictive modelling to identify people who are likely to need care and support in the future

- Empowering people to self care - recognising the wealth of local community providers that support people and their carers.
- Integrating primary care with community services
- Integrating community health services with hospital services
- Integrating physical and mental health services
- Integrating health and social care

The Health Outcomes Benchmarking Pack for Leeds highlights avoidable emergency admissions, readmissions and differences in life expectancy as areas we need to improve on, all of which relate directly to the opportunities offered by integrated health and social care services. Twelve co-located integrated health and social care neighbourhood teams across the city now coordinate care and support around the needs of older people and those with long term conditions. Focused on clusters of GP practices and their registered populations, teams work together with primary care, using outputs from risk stratification to provide an opportunity for proactive input to prevent ill health and deterioration of health. Core teams, with practitioners becoming more generic and therefore more able to focus on the whole person, draw on specialist support when required, and are also supported by consultant input from geriatricians and Long Term Conditions consultants providing expert advice and back-up, community based medical assessment and support for community based beds. As the building blocks of our adult integration delivery model **(Appendix 7),** the neighbourhoods provide an opportunity to build relationships with third sector providers and other community assets to ensure appropriate care and support and effective resource utilisation that crosses organisational boundaries and further enhances integrated working. Work at the secondary care interface aims to improve communication between hospitals and neighbourhood teams to prevent inappropriate admissions and reduce lengths of stay.

Recognising that most older people with dementia also have physical health problems for which admission to hospital is not uncommon, we are looking at opportunities to develop the interface between community mental health teams and the neighbourhood integrated teams - upskilling generic staff to manage mental health as well as physical health needs; realigning existing primary and secondary mental health services to fit better with the integrated neighbourhood teams; and identifying where there are gaps and considering options to close them. Older people and adult mental health teams have already been integrated and, at the same time, social workers have been integrated into community mental health teams.

Our new fully integrated health and social care community bed unit helps to prevent hospital admission and facilitate earlier hospital discharge, supporting people through an intensive period of recovery, reablement and rehabilitation. Jointly commissioned by the CCGs and Adult Social Care, this service is provided as an integrated approach between Leeds Community Healthcare and Adult Social Care, enabling seamless care pathways with the neighbourhood integrated teams. In its first month of operation, it is already showing a 50% reduction in length of stay compared with our previous model for community beds.

We have dynamic primary care providers in the city who recognise the fundamental changes that need to occur in the provision of their services in order to meet the needs of their patients, and there is an active debate about how this might happen. We are supportive of those practices that may come together as federations and the central role they wish to play in integrated community care.

Leeds has a strong commitment to putting the individual at the centre of the health and social care system, working with the strengths of people and communities to foster resilience, reciprocity and support self care. This work has been progressed over the last two years with support from the NESTA People Powered Health Programme, ensuring that the three prerequisites of a) an empowered individual, b) a skilled health and social care workforce committed to partnership working and c) an organisational system that is responsive to people's needs and considers the whole person, are at the heart of our strategy. So far we have:

- Commissioned consultation skills training for front line staff based on the nationally recognised approach 'Making Every Contact Count'
- Strengthened relationships with community provider organisations in the neighbourhoods – community asset mapping (building on the success of the Leeds Directory); close working with Neighbourhood Networks; joint working with Age UK who have secured funding to work with up to

30 GP practices in the most deprived areas of the city to ensure the most vulnerable older people have a support plan that meets all of their needs
- Developed community brokerage – Local Links – involving Neighbourhood Networks supporting people to plan their own personalised care linked to increased social capital
- Recognised the crucial role of carers in supporting people with health problems, and the support that carers themselves need to continue caring
- Focused on Making it Real – our first priority being 'having the information when I need it'

6. Stakeholder commitment

We see the delivery of integrated health and social care as a whole Leeds commitment, signed up to by all stakeholders – people who use services, carers, health and social care commissioners and providers, third sector, public health and wider council. This application confirms our direction of travel and is consistent with our shared desire to be the best city for health and wellbeing.

We have a strong Health & Wellbeing Board (comprising of representatives from the three CCGs, local authority, NHS England, the Third Sector in Leeds and Healthwatch Leeds), fully committed to and already delivering on its duty to promote integration and partnership working between the NHS, social care, public health and other local services. Through its shadow phase over the last eighteen months, the Health & Wellbeing Board has been involved from the beginning of our journey to integration; shaping direction and the stakeholder engagement process. For the last two years, leaders across the health and social care system have worked together as a Transformation Programme Board, with clinical leadership, to drive forward an ambitious programme of change in the city, including the development of innovative models of integrated care and support. The Children's Trust Board oversees transformation in children's services. As part of Leeds' commitment to making joined up commissioning decisions, the Integrated Commissioning Executive, comprising of representatives from the Local Authority, CCGs and NHS England, is fully signed up to this agenda.

At a strategic level, the third sector is represented on the Health & Wellbeing Board and the Transformation Programme Board, and is committed to the integration agenda. We also work directly with third sector providers and via their infrastructure organisations, to ensure the best possible outcomes through meaningful and effective partnership working.

Our Charter for Involvement in Integration and our Disabled Children's Charter, both co-produced with people who access services and their carers, include a clear expectation that the views of people who use services will be integral to the reshaping of those services, and we are committed to providing feedback on how those views have been incorporated into our plans. Staff groups across health and social care have also been involved from the beginning in the development and implementation of our plans for integrated services.

7. Capability and expertise to deliver at scale and pace

We have already achieved a lot in Leeds – across both children's and adults' services – in a relatively short time, which demonstrates the vision, commitment and expertise that we have here. The progress we have made in the last two years is demonstration of our ability to deliver, and we will harness that to take our achievements to the next level. We are already attracting many requests for visits from around the country, and our progress has been recognised by key national figures - Sir John Oldham, Norman Lamb, Louise Casey and others – who have visited Leeds. As a city, our Chief Executive is a leading voice in developing local government to be fit for the future, and we have the highest calibre of people from the Information Centre, academia and clinical leadership supporting our approach, with many of our local leaders having national profiles in their own professions. Through our Transformation Programme, we have committed significant resources and change management expertise to support our work to make integrated services a reality. The strong local leadership and governance structures described elsewhere in this document will underpin our continued ability to deliver at scale and pace.

We recognise that there are a number of barriers that have the potential to reduce the pace of integration if they are not handled properly, so we are already tackling them head-on, for example:

- **Culture change** – bringing together different organisational cultures requires organisational development to sustain and embed new ways of working. We have invested in development of our new teams, and a willingness to create time and space for staff from different organisations to understand one another's roles, align goals and work together. We have invested in defining the integrated workforce of the future – the move to a more generic workforce; shift from expert model to truly person/family centred/led; putting people in control of their own care – and really embedding the principle of 'no decision about me without me'. We will work with the Local Education and Training Board and Health Education England to ensure that new workforce requirements are identified and acted upon.
- **Information sharing/governance** – sharing information appropriately to support better coordinated care and support. We welcome the recent Dame Fiona Caldicott review findings that will make the sharing of information for direct care purposes much more straightforward. To support this, the NHS number is now being used as the unique identifier across health and social care in Leeds, with 88% of adult social care records now having NHS numbers. Adult Social Care has also achieved 'level 2' in the NHS Information Governance Toolkit, thus providing the necessary assurances required to underpin the sharing of direct care information. Our work on information governance, consent and data sharing agreements ensures that we adhere to the principles of the recent Caldicott Report and NHS constitution on data sharing. Leeds is embarking on an ambitious project, funded nationally, with support from local public services across England, Health and the Cabinet Office, to fast-track the development of a new integrated Public Services Information Governance Toolkit to provide a new approach and wider framework to the convergence of the plethora of Information Assurance regimes across Government. When delivered, this common approach will save the public sector millions of pounds whilst providing appropriate and proportionate information assurance arrangements. The development of Leeds Care Record will enable the relevant information to be available wherever someone presents in the system.
- **Estates** – co-location of staff from different organisations is critical to the development of integrated services. We have taken a pragmatic approach so far in Leeds, and used existing NHS, school and community estate to bring our neighbourhood teams together. However we know that, in some cases, this is not a sustainable solution and we need to take a new look at how we use our estates, supported by new technologies, to support integration. The Transformation Programme Board has committed to the development of a citywide estates strategy to support integration.

8. Commitment to sharing lessons

Leeds has an excellent record of sharing learning and innovation. We have already showcased our work on integration and shared our learning with visitors from across the UK; as part of the Yorkshire & Humber LTC Commissioning Development Programme; as a pilot site for the NESTA People Powered Health Project; and as an Early Implementer site for the Long Term Conditions Year of Care Tariff Project. Leeds also has a profile for innovation and integration in children's services. Leeds was a first wave Early Implementer Site for the Chief Nursing Officer's 'Call to Action for Health Visiting'; we delivered the new national model through the integrated Early Start service and have shared our approach at numerous regional, and national events, which included a presentation to the National Health Visiting Taskforce. As a pioneer site, we will work with Central Government to continue to publish and share our approach to integration as we go along, open our outcomes to others, and host an annual national conference in Leeds.

9. Robust understanding of the evidence

As well as drawing on national (particularly the recent King's Fund and Nuffield papers) and international evidence, Leeds has also already invested significantly in creating evidence for integration. We understand the need to measure our success, and we can already demonstrate an impact at an individual, staff and system level. Case studies provide evidence of qualitative impact for service users who say that: "A more integrated approach is making a big difference" **(Appendix 8)**, and staff who say that: "if we hadn't worked together, [people we look after] would be in residential care by now" **(Appendix 9)**. Our unique integrated dashboard and Care Trak information provide the quantitative baseline and ability to track our quantitative metrics **(Appendix 10).** Whilst it is early days, we are already seeing reductions in hospital lengths of stay and long term care placement bed weeks. Leeds saw a reduction of 3.2% in bed weeks in care homes for

older people in 2011/12, and a further 1% in 2012/13 – suggesting that people in Leeds with complex needs are increasingly being supported to live at home successfully.

The University of Leeds is supporting us to develop a sustainable approach to evaluation, based on the outcomes framework mentioned earlier in this document. Our evaluation includes qualitative, quantitative and health inequalities dimensions - including an innovative approach to evaluation of service user experience, using the third sector to train researchers who will then conduct interviews with service users and carers. Our bespoke informatics solutions underpinning the quantitative evaluation include longitudinal studies of individuals receiving more coordinated care and support through our integrated approach.

Professor David Thorpe (Lancaster University) is supporting evaluation of how an integrated 'front door' to children's social care better targets and manages demands for social care assessment. Nina Biehal and Professor Mike Steen are supporting improvements in how outcome based care planning improves joint outcomes for looked after children. We have also developed a joint performance dashboard to underpin children's integration in our Early Start service, providing a single view of Healthy Child Programme delivery, safeguarding needs and demands, performance and public health outcomes performance – all at citywide and team level **(Appendix 11).**

As a pioneer site, we will share the work we have done already on evaluation and the development of measures, and work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support, and participating in a systematic evaluation of progress and impact over time.

10. Conclusion

As a city that is first for health innovation, Leeds welcomes the opportunity to be recognised as an integrated health and social care pioneer, through which we believe we can push further and faster on all three themes of our strategic approach to integration. To that end, we would welcome national expertise to provide additional support in the following areas:

INNOVATE - support the development of new solutions and approaches, by:

- supporting the developing open standards and open source systems and a uniform information governance model to support integrated working across multiple commissioners and providers
- providing a quick route of access to sound out ideas, giving permission to push the boundaries, and supporting us to take managed risks

COMMISSION - **support to create new care and funding models, by:**

- better understanding and interpretation of data, heath economics and redesign of payment systems
- working with us to pilot new person centred care models e.g. procurement and contracting arrangements, annualised decision making, tariffs, rates of return
- using primary and community services in our city as a test bed to help shape the primary care contract to support integration

DELIVER - support to build on our existing successes, by:

- promoting good local practice across the whole system
- working with us to shape organisational design, workforce design, integrated workforce strategy and mapping both current and future workforce education and training needs
- developing templates and approaches that will be shared and applied nationally
- clearly communicating to the people of Leeds what we want to achieve together, why it is relevant, and - most importantly - how it will improve quality of care.

We are committed to sharing the good work we have already done in Leeds. With national support we believe we could accelerate what we are doing – for replication and adaptation across the country to deliver better outcomes through integrated health and social care on a national and international scale. We look forward to the opportunity to make a real and positive difference to lives in Leeds and beyond.