Better Care Fund planning template

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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:	**12/02/2014**
Date submitted:	**14/02/2014**
Minimum required value of ITF pooled budget: 2014/15	
2015/16	**£54.9m**
Total agreed value of pooled budget: 2014/15	**£2.759k**
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	12.2.14

Signed on behalf of the Clinical Commissioning Group	Leeds North CCG

By	Nigel Gray
Position	Chief Officer
Date	12.2.14

Signed on behalf of the Clinical Commissioning Group	Leeds West CCG
By	Philomena Corrigan
Position	Chief Officer
Date	12.2.14

Signed on behalf of the Council	Leeds City Council
By	Sandie Keene
Position	Director of Adult Social Services
Date	12.2.14

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	12.2.14

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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. This excellent track record has resulted in the city being selected as one of 14 national Integration Pioneers. For more information on our work to date, please see www.leeds.gov.uk/transform

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. It has been led by the Integrated Commissioning Executive and the Directors of Finance Forum, chaired by the new Chief Executive of LTHT, developed a methodology and mechanism to work through the BCF proposals in detail to quantify the impact on both activity and cost of the schemes to ensure the necessary savings are being generated and to ensure that there is no double counting between commissioner and provider QIPP plans.

In addition to existing arrangements, the BCF plan has been developed through a series of BCF-specific, well-attended workshops. It has been supported by a number of existing boards which have senior representation from all service provider organisations. These boards have developed the schemes outlined the BCF for Leeds:

- Transformation Board
- Integrated health & social care board
- Urgent care board

- Informatics board
- Palliative care strategy group
- Dementia board

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

We are dedicated to maintaining parity of esteem between physical and mental health services.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Whilst the nationally set timescales have not permitted a formal consultation with the public in Leeds to date in relation to the specific activity of completing the BCF template, it is anticipated that HealthWatch Leeds will lead a fuller consultation process later in 2014 once the plan has been signed off in order to shape and develop the delivery of the schemes.

Patients, service users and the public have played, and will continue to play, a key role in the development of sustainable plans for health and social care in the city. 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 was co-produced with people who access services and their carers, 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. 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.

Finally, the NHS Call to Action 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.

e) 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	Synopsis and links
BCF Leeds – Supplementary information	This document explains in more detail the make-up of the Leeds BCF and the

	initiatives that will be pursued in the city next year. It also provides a more detailed rationale on the metrics that have been selected locally to measure and monitor progress.
Appendix 1 - Charter for involvement	
Appendix 2 - Leeds integrated health and social care pioneer bid	
Appendix 3 – Leeds £ plan on a page	
Appendix 4 - Leeds Integrated Health & Social Care Outcomes Framework	
Appendix 5 – Integration dashboard	

VISION AND SCHEMES

a) Vision for health and care services

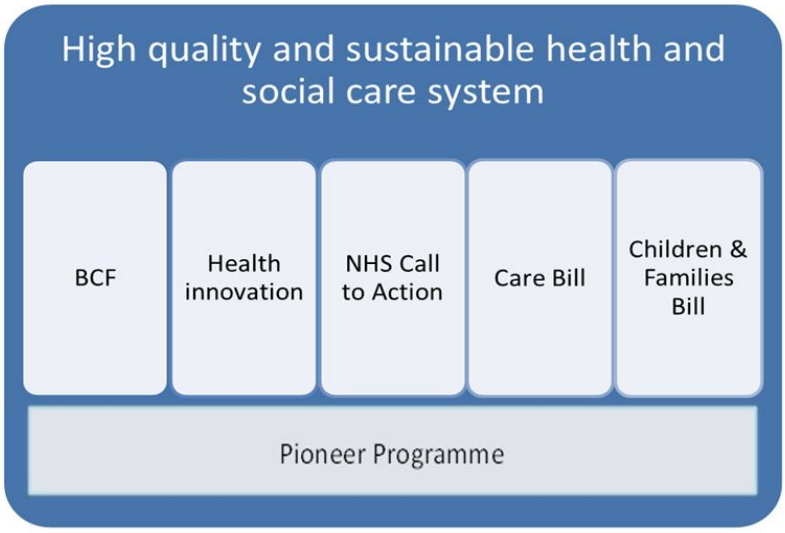
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

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.

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. Our shared vision is to create an efficient, effective and sustainable health and social care system which aims to place Leeds at the forefront of both national and international models of care and support. We aim to achieve excellent outcomes for the people of Leeds, deploying individualised and innovative solutions to the totality of their support and care needs.

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.



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 people of Leeds will be able to access further community facilities of this nature.

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 interdisciplinary endeavour. Services must be based around the needs of people, not around organisations.

The integrated health and social care model in Leeds has been developed around three core themes:

- Supported self-management
- Risk stratification
- Integrated health and social care teams

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:

1) Making best use of risk stratification tools to identify those who could benefit most from more targeted and holistic support and care; and
2) 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.

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 within the whole system of care 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 as we endeavour to spend the "Leeds £" wisely (see the diagram at appendix 3). The creation of the Better Care Fund enables the health and social care community in Leeds to accelerate its progress towards that goal, establishing appropriate governance between all partners involved and ensuring the appropriate sharing of risk and reward through the whole system.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

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". 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

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, as a national Pioneer, 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 supplementary information section.

How we will measure

There are positive signs from the Leeds Integrated Health & Social Care Outcome Framework (Appendix 4) 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 (Appendix 5). 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.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Leeds' schemes blend existing programmes of work which we know are delivering results with more innovative proposals.

We have benchmarked our 'long list' of proposals against work happening in other cities, exploring what similar schemes have worked well and what evidence of impact on outcomes for both people and finances is available.

The BCF plan draws on the excellent work already in train in Leeds. A number of schemes have begun in 2013/14, with a full evaluation taking place in 2014/15, for example, the winter pressures initiatives. During the course of 2014/15, where there is agreement to focus on a particular area (e.g. falls), but it is not clear at this stage what intervention would be of the most value, work will be undertaken to review the service and recommend how non-recurrent funds through the BCF might be best utilised for the biggest impact. In most cases, work will start in 2014/15 and progress into 2015/16; we will use this time to 'learn as we go'. It is widely recognised that there is a lack of robust evidence available nationally on the impact of shifting the balance from acute to preventative services and a lack of health economics expertise to model this. As a Pioneer, we will take risks and accept our BCF, as part of our wider Transformation programme, will be an iterative process. However, the rigorous process of testing and evaluation we have put in place will enable us to be confident that we are investing in what works locally – and will allow us to contribute to growing the evidence base nationally.

The complete list of schemes and initiatives is included in the supplementary information to this submission. Schemes are split into those that will be recurrently funded and those that will be achieved through non-recurrent funding housed within the BCF scheme. In total there are over 20 schemes, and the appendix gives detail about aims, objectives, required investment and anticipated savings.

The priorities of the strategy were developed following the robust work to compile the city's Joint Strategic Needs Assessment, which sets out the challenge to the health and social care system of a growing older population and associated need to support people with long-terms conditions.

The BCF and all related plans and activity are aligned to the Leeds Joint Health and Wellbeing Strategy. It should also be noted that whilst the BCF represents £54.9m of expenditure, the whole health and social care commissioning budgets amount to approximately £1.5bn and therefore it is recognised across the whole health and social

care system that the BCF alone will not address the city's financial challenge.

We will ensure that we will maintain alignment of plans through the reporting mechanisms and governance structures agreed, or developed during our shadow year.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The Leeds health and social care economy is facing an underlying deficit of over £100m a year. Leeds Teaching Hospitals NHS Trust is looking at around a £250m deficit over the next 5 years; 2015/16 is the year presenting the biggest challenge. Savings need to be identified not only to plug this gap, but also to free up monies to allow investment in more joined up community based services.

A reduction in emergency acute activity is the main driver for commissioners in Leeds to generate savings for both the health and social care commissioners and provider in the city. In their emerging 5 year strategy, Leeds Teaching Hospitals NHS Trust has stated its intention to deliver seamless integrated care across organisation boundaries, with a reduction in urgent admissions for frail elderly patients and those with long term conditions by 20%. In order to realise these savings, there is a need to also invest in preventative measures through better integrated working and more joined up care in the community.

Realising savings through reductions in hospital activity is a big risk for the city - the most obvious implication is that the NHS in the city becomes financially unsustainable and service delivery targets fail to be met. The targets most at risk include:

- Failure to meet the RTT 18 weeks elective care target – due to increased pressure on beds from acute admissions
- Failure to meet the A&E 4 hour waiting time target

Increasing community capacity should act not only to promote the integration agenda, but also to support the delivery of these key performance targets.

Changes in finance and commissioning arrangements are also key to generating savings. Leeds is a Year of Care pilot and recent work, carried out by the Year of Care tariff working group, has looked to identify patients who have remained in hospital beyond the point at which they were medically fit for discharge. The work found that over a third of patients were staying in hospital beds longer than was clinically necessary, but these patients attract the same tariff as a patient who goes home earlier. Commissioners in Leeds are looking at more intelligent commissioning and contracting models that will incentivise timely discharge, and tariff arrangements that reflect the actual amount of time someone stays in hospital - thus generating further savings for the Leeds pound.

Health and social care commissioners in the city are also mindful that hospital based care must be sustainable and given the scale of specialised activity at Leeds Teaching Hospital it is imperative the development of an acute strategy for Leeds is cognisant of the approach of NHS England to specialised services commissioning. It is crucial that as

less money and activity is delivered in the acute sector as a result of the BCF initiatives, costs in that sector either reduce or are refocused on specialist activity.

Therefore, it is essential to develop a citywide plan which factors in the commissioning intentions for specialised services. Savings in the health and social care sector need to be generated by shifting activity into the community, and making the entire sector more focussed on prevention.

The hospital itself also needs to become more efficient to ensure that it remains sustainable. Leeds Teaching Hospital NHS Trust's goal is financial stability, with a recognition that efficiency savings of 18 – 20% must be made over the next three years. This will be achieved through: treating patients differently who do not need to be in hospital length of stay, purchasing and the innovative use of information technology. At the same time, we need to ensure that acute services in Leeds continue to provide excellent patient care, develop an effective and caring workforce and lead on research, innovation and education.

If costs in the acute sector are to be shed, in practical terms, this means reduced staff in the acute sector. This is within the context of a shift to 24 hours, 7 days a week working and so innovative work with staff to develop pioneering solutions is crucial. As a consequence of moving to a more prevention focussed agenda, workforce redesign is a priority. As acute activity starts to fall off, and community activity rises, re-training the workforce will become increasingly important and workforce development to meet changing needs is part of our wider transformation programme. Roles that were once only available in the hospital will still be required, but in a different setting. In the longer term, the BCF will need to have a scheme focussed on workforce and training to ensure we have the correctly qualified staff working in the right places and with the right patients to create the integrated health and social care system patients, service users and their families deserve.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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, 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.

The responsibilities relating to the fund manager role will be determined prior to the final submission date in April.

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.

2) NATIONAL CONDITIONS

a) Protecting social care services

At a time when we are planning to make significant investments in community-based, person-centred health and care services, we are seeing rising demand on our health and care services as a result of changing demography and as we get better at keeping people alive longer. Against this backdrop, local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.

Our BCF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and social care system as a whole. We recognize that the BCF alone will not resolve the financial challenges faced by Social Care, but we are confident that as part of the overarching transformation plans in the city, these will be met.

This means:

- Supporting people to live independently and well
- Releasing pressure on our acute and social services
- Investing in high-quality, joined-up care in and around the home

Protecting social care services in Leeds means ensuring that those with eligible needs within our local communities continue to receive support, despite growing demand and budgetary pressures.

Our primary focus is on continuing to develop new forms of joined up care which help to ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and social care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services.

This is illustrated by Adult Social Care's 'Better Lives for People in Leeds' strategy – our commitment to supporting people to live independently and giving them more say in how they live their lives. Our ambition is to make Leeds a place where people can be supported to have better lives than they have now. Over the next five years, we intend to continue our achievement towards this through a mixture of enterprise and integration, where the council join up with health and other service providers to create an adult social care sector that is varied, accessible to all and fit for its purpose. For more information, go to: www.leeds.gov.uk/betterlives

Underlying our vision are the nationally-accepted priorities for social care in the UK, which are:

- Enhancing the quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

Funding currently allocated under the Social Care to Benefit Health grant has sustained the current level of eligibility criteria and ensured the continued provision of timely assessment, care management and review, together with the commissioning of services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. As part of the BCF financial model, the proposal is to sustain and protect the current level of health funding to support social care (£11.9m-£12.5m plus £2.8m reablement) with CCG QIPP programmes used to set up the BCF to develop a recurrent investment fund to transform the social and health care system. This will be the primary mechanism to protect social care services through health spending focusing on reducing demand to services.

As part of the next stage in the development of the BCF health and social care will work together to further develop the programmes of work which will result in additional schemes being developed that benefit the health and social care economy. This may well add further funding to social care to schemes to enable the transformation of the city.

This is required due to the continued financial pressures facing all partners in the BCF. Prior to the consideration of the impact of further Local Authority funding reductions on Social care, Leeds Social Care are facing unidentified CIPs of £7.2m in 15/16. To maintain essential services at current levels of eligibility, savings generated through the BCF process will be focused on addressing this shortfall as well as the future QIPP challenge facing the NHS. Potentially upwards of an additional £15m contribution to the Councils' wider CIP programme may be required by Social Care in 15/16. Decisions have yet to be made on the level of this contribution to date, however, and further discussions

will be required to identify the size of this gap. The focus on the BCF will be to demonstrate a contribution towards mitigating some of these additional pressures through the services developments proposed. However, given the size of the financial challenge faced by Social Care, the challenge will not be met by the BCF alone, but by a commitment of all partners to meet the collective financial challenge for the Health and Social Care economy, of which Social Care is one part, through the established H&SC Transformation programme in the city.

In addition, it is also recognised that, nationally, the BCF includes provision of £185m (£50m of which is capital) for 'a range of new duties that come in from April 2015 as a result of the Care Bill.' Although this funding is not ring fenced, the Leeds BCF includes a draft scheme which could be up to £2.7m non recurrent (£0.7m of which is capital), although further work will be required to quantify the impact of this scheme.

Adult Social Care has a very strong track record of delivering significant efficiencies and has delivered over £70m in the last 5 years to enable ongoing financial challenges to be met, whilst at the same time improving the quality of services to people. These efficiencies have been delivered through a range of measures including the significant decommissioning of in-house services, service redesign and investment in preventative services, together with the implementation of innovative, jointly commissioned and provided social care schemes including the South Leeds Independence Centre, Reablement Service, Integrated Neighbourhood Teams, the Assistive Technology Hub all as part of our ongoing 'Better Lives' programme.

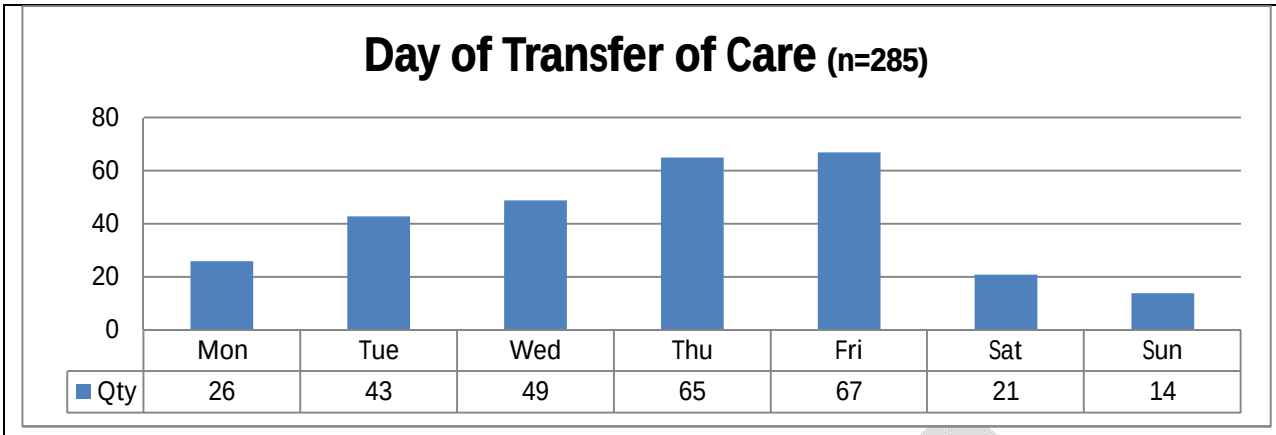
The BCF clearly represents a further opportunity for health and social care to work together to deliver significant savings through more integrated and efficient working, while ensuring that care provided to the people of Leeds remains of the highest standard.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

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.

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.

But simply having services available seven days a week isn't enough. Services across primary, secondary, community and social care also need to be co-ordinated. We already have several well established seven day established community services, for example, district nursing and joint care managers, and have begun to further enhance other service availability including:

- A service looking at facilitating early discharge called the "Early Discharge Assessment Team" (EDAT). There is evidence that this team has actively avoided hospital admission.
- The winter pressures work has piloted 7 day working for the Community Equipment Service in 2013/14. Subject to the results of evaluation, it is anticipated that this will be rolled out through the BCF.

However, the role out of seven day services also requires fundamental and large scale change to existing services. There are a range of schemes targeting seven day working. These are set out in the supplementary information section. Part of developing detailed plans for the BCF need to take in to account the cost of moving to seven day service and equally the potential savings from operating uniformly during the week. This will be developed further before final submission using best practice and an evidenced-based approach.

Current CCG contract negotiations with providers are taking account of 7 day working.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

As part of our Pioneer bid, we outlined our innovative practice in this area, through the development of the Leeds Care Record. 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 three GP practices and would not have been possible without Leeds' commitment to use of the NHS Number.

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.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

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). The strategic aim is to implement this before April 2015, 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.

Please confirm that you are committed to 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 confirm that you are committed to 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.

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.

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

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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 next year provides an opportunity to adapt the way in which the tool is used. The tool will need to be used to identify the top 2% high risk patients from each practice and from that will also need to 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 motive further joint working, a complimentary CQUIN will come into effect in April 2014. The CQUIN will incentivise community health services to work in a more multi-disciplinary way with primary care, to deliver improved proactive care management.

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 should 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 through 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.

RISKS

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

Risk	Risk rating	Mitigating Actions
The savings and efficiencies needed to fund whole system change that meets people's health and social care needs may not be delivered through the work planned.	Very high	The proposals within the Better Care Fund submission have been costed and likely efficiencies estimated. There is very little evidence base with few examples of full implementation of schemes. Progress post implementation will be closely monitored but likely impact will be based on a culmination of interventions.
In order for the hospital sector to release efficiencies, it will need to close beds as activity drops.	Very high	Leeds Teaching Hospitals Trust plans outline how beds within the acute sector can be closed without destabilising the sector. Impact of specialist commissioning strategy key to understanding overall strategy for LTHT
Work carried out under the Better Care Fund will need to be managed and monitored. Resources have not yet been identified to undertake this essential function. NHS facing 10% real terms budget cut in administration in 2015/16	High	Resources are being discussed and will be allocated from both health and social care.
Shifting resources to fund new schemes may destabilise current services and providers, particularly in the acute sector.	High	Proposals been jointly developed by health and social care organisations across Leeds, including service providers. This has enabled a holistic consideration of the benefits and dis-benefits of each proposal
Work outlined may not adequately ensure the Protection of Adult Social Care services.	High	The Protection of Adult Social Care Services has been fundamental to the development of proposals and of Leeds' wider ambition of a high quality and sustainable health and social care system. The focus has been on protecting existing spend whilst developing an investment pool to invest to reduce overall health and social care spend.
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.	High	Proposals include investment in infrastructure and development to support overall organisational development.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and	High	Proposals have been developed using a wide range of available data. 2014/15 will be used to test and refine these assumptions,

nursing / home care activity by 2015/16, impacting the overall funding available to support care services and future schemes		with a focus on developing detailed Business Cases and service specifications
Leeds may suffer reputational damage if the city fails to deliver the outcomes detailed, especially as there is a public perception that the BCF represents new money and will deliver additional services.	Medium	Proposals have been developed through a rigorous process of consultation and engagement, review and scrutiny.
The introduction of the Care Bill may result in a significant increase in the cost of care provision from April 2016 that it not currently fully quantifiable and that will impact on the sustainability of current social care funding and plans.	High	The Care Bill is a fundamental part of Leeds' work towards achieving the ambition of a high quality and sustainable health and social care system. Specifically, a Chief Officer with specific responsibility for Social Care Reforms has been appointed to plan for the introduction of the Care Bill and monitor its impact.
Community and social settings may be unable to pick up increased demand as care moves away from acute settings.	Medium	Savings generated through work under the Better Care Fund will be used to increase capacity in community and social settings.
It may be impossible to realise plans because Leeds CCGs are not the primary commissioner for all primary care services and are dependent on NHS England Area Team Specialist Commissioning plans.	Medium	NHS England are part of ICE and TransformatIon Board
The lack of detailed baseline data and the need to rely on current assumptions may mean that financial targets are unachievable.	Medium	Proposals are based in all available information and will be refined as work progresses.