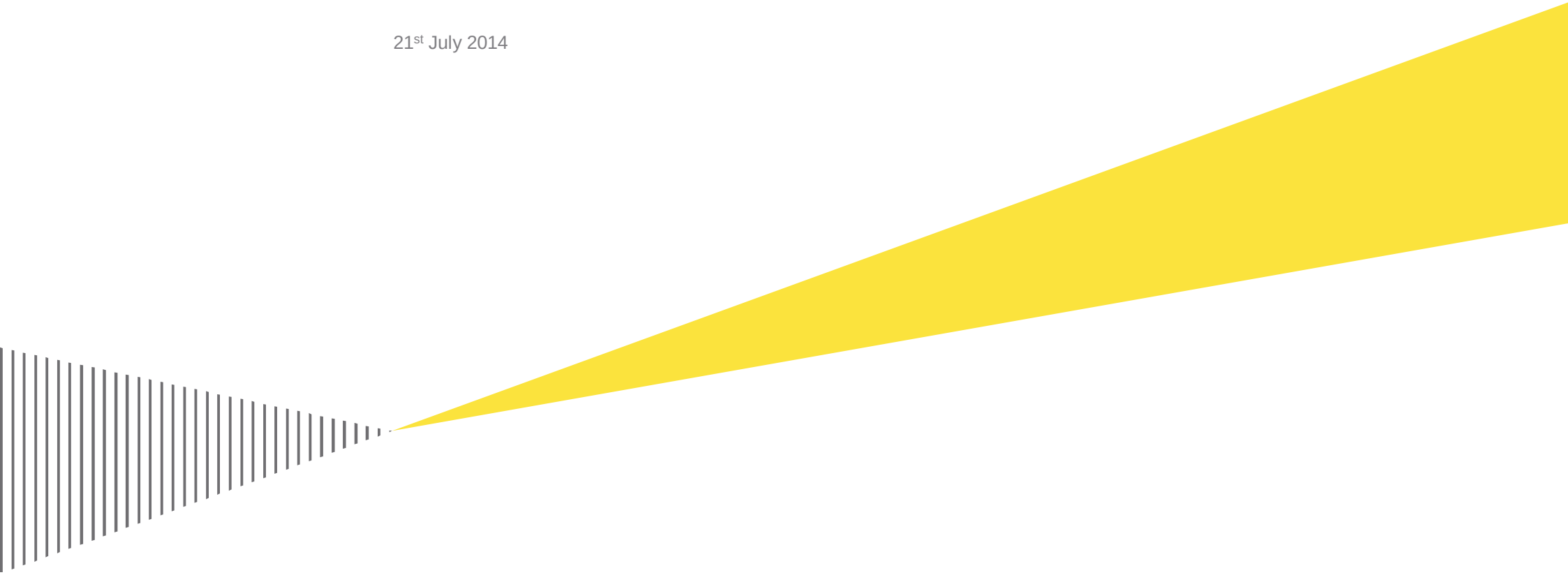
NEL CSU: BCF Review

Leeds BCF Deep Dive

21st July 2014



Building a better working world

Contents

Section 1

Background and context

Background to the Better Care Fund Plan

The BCF process

The creation of the Better Care Fund (BCF) is a landmark policy which will drive local NHS organisations and local government to work together to integrate care services. Its aim is to stimulate a major transformation of the way health and care services are delivered and, ultimately, to improve lives, quality of experience and quality of outcomes.

Over the past six months, each Health and Wellbeing Board has developed a local BCF Plan. These plans were submitted as draft (14th February 2014) and final (4th April 2014), following early feedback. Revised BCF Plans were subject to an assurance process led by the Local Area Team (LAT) and further clarification sought from each area where required.

Following the submission of revised Plans, a number of issues were identified in relation to the realistic and achievable delivery of plans and the impact on acute providers. A further iteration of the BCF template has been developed to specifically address these issues, and a number of BCF sites have been requested to participate in a fast-track process to trial the new templates and resubmit revised BCF plans. These fast-track plans are now subject to 'deep dive' with the aim of producing a set of exemplar plans underpinned by a development approach that can be replicated more widely

BCF 'deep dive '

The use of deep dives to further enhance the best plans is an innovative approach which involves working with some of the most forward-thinking and well-developed integrated teams in different localities to not only produce an array of exemplar plans, but to fathom a way that less well-developed LA/CCG partnerships can make similar progress. In this way, there will be a tangible route to improving BCF plans and their implementation.

EY role and approach

EY were commissioned to undertake a deep dive review of the Leeds BCF Plan, and to provide a report which focuses on the three following areas:

- ► Feedback on Leeds BCF Plan
- ► Feedback on the new BCF template (taking into account recent policy changes on Payment by Performance)
- ► Explain our methodology to feed into the review of the remaining BCF sites

Our approach included the following steps:

EY interviewed a small number of key stakeholders involved in developing and assuring the Leeds BCF. We are grateful to these people for their input. A list of interviewees is available in appendix A.

EY conducted a limited desktop research into the Leeds BCF, including reviewing the revised BCF Plan, a number of papers provided by the Leeds BCF Programme Team, Leeds City Council Adult Social Care, and other local working papers.

After the desktop review and interviews, the findings have been iterated to form this report, which includes the outputs from our work.

The report is set out as follows:

Feedback on the Leeds BCF Plan: which includes EY's outline view of how the Leeds BCF has met the requirements of the BCF Plan, and recommendations for actions which Leeds could undertake to further improve their Plan; and

Feedback on the BCF template: which includes EY's view of the fitness for purpose of the current BCF template, and recommendations for how it could be further improved to a) help BCF sites to provide the required information, and b) reviewers to assure the Plans.

Review methodology: which includes details of the method we used to undertake the deep dive review and recommendations for how this can be used by others to review and assure the remaining BCF Plans.

The findings and recommendations in this report are not exhaustive and are limited on the basis of the analysis that was conducted, as set out above.

Section 2

Review of Leeds BCF Plan

2.1 Overview of Leeds BCF review

The Leeds BCF plan has been identified as a high quality plan and selected for a deep dive review. The purpose of the deep dive process is to develop a number of exemplar BCF plans to support other local areas to improve their own plans.

Overall the Leeds BCF plan is a strong plan. While there are a few areas which need further work, the plan broadly meets the requirements of the current template. There are some sections which are of particularly high quality, such as the link to the JSNA and JHWBS to ensure schemes are addressing local need, and the work on data sharing which goes above and beyond the requirements of the BCF.

During the time this deep dive review was taking place, a new policy direction was announced around payment for performance. This guidance sets out that the only metric which will be linked to performance payments going forward is reduction in emergency admissions. While the other metrics are still considered important, they will no longer be linked to performance payments in the same way.

This new policy may create a number of issues, both nationally and locally for Leeds. These are set out below.

1) The original aim of the BCF was to pool heath and social care money and use it to invest in jointly agreed services to achieve five national metrics which crossed health and social care. While the aim of the BCF is the same, the change in payment for performance means that, in reality, schemes must now focus primarily on reducing emergency admissions. This will reduce the focus on considering the system as a whole and could have a detrimental effect and reduce the likelihood of success. The continually shifting goal posts make it challenging for local areas to begin making the necessary investments because of the ongoing uncertainty about required outcomes.

2) The new payment for performance metrics arguably offers financial protection for the NHS which is not provided in the same way for local authorities. If emergency admissions do not decrease, CCGs will receive the funding to pay for the activity. If residential care admissions do not decrease, the local authority does not have the same financial protection. This lack of equal footing, and refocussing on issues facing the NHS over Local Authorities, could damage working relationships which would be extremely detrimental to the success of the BCF.

Organisations in Leeds have strong working relationships but nevertheless we have received feedback that the new guidance has put a strain on these relationships. In less mature areas, this could have a more enhanced effect.

3) It needs to be made clear when the new performance related payments will be made. Leeds are fortunate that they have a contingency fund within their BCF plan and this can therefore be held back (see point 4 for further discussion on this). However, some local areas have made up their BCF fund with 100% committed spend. These areas will therefore struggle to fund their schemes if the performance payments are made later in 2015/16, which will in turn reduce the likelihood that they will meet the target.

4) The Leeds BCF contingency fund currently stands at £2m. Work is underway to work out the value of a 3.5% reduction in emergency admissions and the value of the contingency will be increased to match this, to provide protection for a scenario in which the target is not reached. Initial indications are that this could reach £5m. This will reduce the amount of BCF funding available to invest in schemes.

5) Local areas are keen to progress as quickly as possible to implementation, and we have received feedback that the drawn out nature of the BCF process and continual re-writing of plans in different templates is extremely unhelpful in supporting this. The new policy will require local areas to re-write their plans again. They will need to rework their finances to take the new policy into account. They will need to review schemes to ensure the existing suite of proposals has the right focus to sufficiently reduce emergency admissions. This will take time and will mean that local areas are spending more of 2014/15 writing plans rather than moving towards implementation and shadow running in preparation for 2015/16.

Our recommendations for how the templates need to be updated to take the new policy into account are provided in section 3. However, we want to highlight the feedback we have received that, whilst it is important robust plans are in pace, local areas need to be given the space to start delivery if their plans are to be successful. NHS England may wish to consider a different process for exemplar sites and pioneer sites which already have high quality plans in place. In this way, these areas could be use for their intended purpose as “trail blazers” to start implementation and provide best practice for other local areas from their experiences.

2.2 Review of the Leeds BCF Plan

When reviewing the Leeds BCF plan we have considered a number of key lines of enquiry. These have been taken from the areas highlighted in the Invitation to Tender, and supplemented with additional areas which EY consider important to defining a BCF plan as “great”.

For each line of enquiry, we have RAG rated the Leeds BCF plan for “completeness” and “quality”. “Completeness” refers to whether or not the Leeds responses meet the requirements of the current template. “Quality” refers to whether or not the information provided in the Leeds BCF plan meets the points we have developed for what a “great” BCF plan would include.

The tables below set out the criteria for our RAG ratings against “completeness” and “quality”.

Completeness	
100% of requirements within the template are met	
>75% and <90% of requirements within the template are met	
<75% of requirements within the template are met	

Quality	
>90% of statements under “a great BCF plan would include” are met within the plan	
>75% and <90% of statements under “a great BCF plan would include” are met within the plan	
<75% of statements under “a great BCF plan would include” are met within the plan	

A summary of the outcome of the review is provided on slides 7 and 8, and a summary of the recommendations is on slide 9. Further detail on each line of enquiry is provided on slides 10-22.

Summary of Leeds BCF review

Line of enquiry	Summary of what good looks like	Completeness	Quality	Reference
Risk sharing arrangements	• Local principles agreed to share risk and benefit between commissioners and plans to take this forward into the Section 75 agreement • Principles in place to share risk with providers which support all organisations to have an appropriate level of risk • Consideration of new contracting mechanisms and organisational forms which would support risk and benefit sharing	NA		2.2.1
Plans are jointly agreed	• Plans signed off by accountable individuals within all signatory organisations • Evidence of co-production between CCGs and LAs • Evidence of meaningful engagement with providers which has allowed them to input into development of BCF plans • Evidence of ongoing engagement; production of the plan is not the end point of this process • Strong working relationships across organisations			2.2.2
Protecting Adult Social Care	• Clear local definition of protecting ASC • Clear statement of which social care services will be protected and to what value • Explanation of how protecting the selected services will deliver health benefits			2.2.3
7 days services in health and social care	• Clear evidence of a commitment to 7 day working • Clear explanation of which services will work 7 days as a result of BCF funding • A timeline and implementation plan for moving towards 7 day working in these services			2.2.4
Better data sharing based on NHS number	• Commitment to the three required areas; NHS number, open APIs and IG controls • Evidence of ambition to move beyond using NHS number to single record system			2.2.5
Joint approach to assessments / single accountable professional	• Description of a robust risk stratification tool and what actions are taken when someone is identified as “at high risk of admission” • A statement of what proportion of the adult population are identified as at high risk of hospital admission • Clear explanation of future process for completing joint assessments, personalised care planning and allocating single accountable professionals			2.2.6
Agreement on consequential impact in the acute sector	• Evidence that acute providers are signed up to the BCF plan • Evidence that acute plans are aligned to the BCF • Basic modelling to show BCF impact on acute sector e.g. “if admissions decreased by x% then the provider would lose £y income from the activity”			2.2.7

Summary of Leeds BCF review cont.

Line of enquiry	Summary of what good looks like	Completeness	Quality	Reference
Proposed schemes are locally relevant	• JSNA used to identify areas of care that could be improved through integration • Proposed changes clearly linked to the JSNA and public health needs, so they are locally relevant • Proposed changes link together to form a clear vision and overarching model for integrated care which addresses these areas • Clear articulation of the difference this will make to outcomes			2.2.8
Clear implementation plan	• Implementation plan which sets out key milestones for delivery • Understanding of critical path to successful delivery which links actions required by all organisations	NA		2.2.9
Governance and delivery mechanisms	• Clear governance structure, supported by a diagram for clarity if required • Description of a realistic delivery model which describes how BCF will be implemented • Description of how delivery will be managed and overseen through the governance structure			2.2.10
Quantification of benefits and benefits management	• Benefits of each scheme clearly quantified • Evidence that a robust benefits management framework is in place, with named people against each benefit • Evidence that a robust contingency plan is in place			2.2.11
Risk management	• Risk log is completed with all key risks • Robust mitigation actions are in place so that residual risk is at an acceptable level			2.2.12
Triangulation with other plans	• Clear articulation of how the BCF plan aligns with 1) the provider plans 2) the CCG two year operational plans 3) the CCG five year strategic plan and 4) the local authority plans which set out targets for the adult social care outcomes framework	NA		2.2.13

Summary recommendations

1) Leeds need to rapidly progress discussions amongst commissioners, and between commissioners and providers, to **confirm arrangements for sharing risk and benefit**. Without these agreements in place, it will not be possible to move towards implementation, or shadow implementation, during 2014/15.
2) Leeds health and social care organisations should **work to maintain their close working relationships** as they finalise the details of individual schemes and move towards integration.
3) Leeds should **include more information about the social care services BCF funding will be used to protect, and how this will deliver health benefits, in the main body of the template** to tighten the structure and provide additional clarity and explanation to the reader.
4) Leeds should **progress with ongoing work to develop a timeline and implementation plan for seven day working**, understand the cost of moving to seven day service and the potential savings from operating uniformly during the week. This would add a further level of detail and clarity to the section.
5) Leeds **rapidly needs to progress work to quantify the impact of the BCF on LTHT and ensure that this is taken into account in the Trust's plan.**
6) Leeds must develop a **robust contingency plan** for a scenario in which these savings are not delivered.
7) Leeds should **link the 22 planned BCF schemes to an overarching model of care**. This would help the reader to understand the overarching transformation that is going to take place. Clearly linking the schemes to the outcomes would also support the reader to understand how the new model of care will deliver these outcomes.
8) Leeds should **continue to develop their BCF implementation plan and ensure there is a clear understanding by all organisations of what actions are required, and the critical path to successful delivery.** Including this in the BCF plan would provide assurance that plans were in place to implement the proposed changes.
9) Leeds should include a **diagram explaining the governance structure** in their BCF plan, which clearly sets out accountability flows. The diagram should also be clear who is responsible for delivery. This could potentially be done very clearly through a RACI, which sets out the accountability and responsibility of each group. It would also be beneficial for Leeds to include an explanation of how the various groups will oversee and manage implementation e.g. frequency of meetings, information they will be provided with.
10) Leeds should **undertake a dependency mapping exercise** to clearly show the interdependencies between the workstreams in their delivery structure.
11) Leeds need to **continue work on developing business cases for the BCF schemes** and finalise these ASAP to quantify the benefits. Leeds need to **develop a robust benefits management framework** and this should be included in the plan.
12) Leeds should **review their mitigating actions** to ensure they are sufficient to manage the impact and likelihood of the risk, and that the residual risk is acceptable.
13) Leeds should include a short section within their BCF plan which articulates **how all the different system plans are aligned and take into account the anticipated impact of the BCF**.

2.2.1 Risk sharing arrangements

What the template requires

The BCF is not new money and as a result, there is risk associated with moving activity and spend from acute services into community based care. This requires the agreement of risk and benefit sharing arrangements between commissioners, and between commissioners and providers. New contracting mechanisms may also be deemed appropriate to ensure that the right behaviours are being incentivised and rewarded appropriately.

This can be done in a number of ways; formal agreements to ensure that dividend and risk is fairly shared across organisations, new contracting models to spread risk and incentivise activity shifts to new organisational forms which share risk more evenly.

The current BCF template does not ask for information about risk sharing agreements.

A "great" BCF plan will include:

- Agreed local principles to share risk and benefit between commissioners and plans to take this forward into the Section 75 agreement
- Agreed principles to share risk with providers which support all organisations to have an appropriate level of risk
- Consideration of new contracting mechanisms and organisational forms which would support risk and benefit sharing

Our assessment of the Leeds BCF Plan

Completeness	Quality
NA	

The version of the Leeds BCF plan that we have been asked to review does not include any information about risk sharing agreements between organisations. The template does not request that this information is provided, and this is commented on further in section 3. We have therefore RAG rated the section as NA for completeness because the template does not state any requirements in this area. Quality is rated as RED because the plan does not include the areas considered important for a 'great' plan.

From discussions with local stakeholders we understand that risk sharing discussions are currently ongoing, but no agreements have yet been made. More work is needed to decide how risk and benefits from the BCF will be shared. Some of the challenges involved in reaching these agreements locally include:

- Deciding which organisation has "first call" on the contingency within the BCF if schemes do not deliver the expected benefits
- How to share benefits, given it will not be possible to establish which schemes (BCF, not BCF or specific organisational interventions) have contributed to any benefit that is delivered
- How to share risk with providers, if they are unable to take out all their fixed costs when income reduces as a result of activity being delivered elsewhere
- How to ensure provider contracts incentivise the desired behaviours and allow risk and benefit to be shared appropriately

Recommendations for improvement for Leeds plan

1. Leeds need to rapidly progress discussions amongst commissioners, and between commissioners and providers, to confirm arrangements for sharing risk and benefit. Without these agreements in place, it will not be possible to move towards implementation, or shadow implementation, during 2014/15.

2.2.2 Plans are jointly agreed

What the template requires

The original rationale for the BCF was to create an "opportunity to transform local services so that people are provided with better integrated care and support". The fund was described as "an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change".

To ensure the fund was use for its intended purpose, one of the national conditions was that plans must be agreed jointly. The guidance set out that plans "*should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups….In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services*"

A "great" BCF plan will include:

- Plans signed off by accountable individuals within all signatory organisations
- Evidence of co-production between CCGs and LAs
- Evidence of meaningful engagement with providers which has allowed them to input into development of BCF plans
- Evidence of ongoing engagement; production of the plan is not the end point of this process
- Strong working relationships across organisations

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan has been signed off by accountable individuals within each CCG, the local authority and the Health and Wellbeing Board. LTHT has also completed Annex 2. The plan describes how organisations across health and social care, including both statutory and third sector providers, have worked to jointly develop the plan. The development of the plan has been led by the Integrated Commissioning Executive, which has enabled close co-development, with a series of workshops run to ensure wider input and engagement from organisations and medical staff, and discussion at other standing board meetings.

The Leeds BCF plan forms part of the wider Transformation Programme. Discussions with local stakeholders have provided insight into the close and trusted working relationships that exist between CCGs and the local authority. An example of this is that CCGs are fully aligned, and each take a lead for commissioning a different part of the health system on behalf of all CCGs; acute, community and mental health.

The BCF plan clearly splits out "BCF engagement" with providers and service users from "ongoing engagement". This is a strength of the plan and demonstrates ongoing work and commitment to engagement and co-development.

Recommendations for improvement for Leeds plan

2. Leeds health and social care organisations should work to maintain their close working relationships as they finalise the details of individual schemes and move towards implementation.

2.2.3 Protecting Adult Social Care

What the template requires

One of the national conditions of the BCF is that it protects adult social care services. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used. A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment"*.

Local areas are required to develop a definition of "protecting adult social care services" and include an explanation of how adult social care services will be protected within their plans.

A "great" BCF plan will include:

- Clear local definition of protecting ASC
- Clear statement of which social care services will be protected and to what value
- Explanation of how protecting the selected services will deliver health benefits

Our assessment of the Leeds BCF Plan

Completeness	Quality

Leeds has defined protecting adult social care as "*ensuring that those with eligible needs within our local communities continue to receive support, despite growing demand and budgetary pressures. This means 1) supporting people to live independently and well 2) releasing pressure on our acute and social services and 3) investing in high-quality, joined-up care in and around the home"*.

The plan proposes 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. Annex 1 lists the social care services which will be protected through the section 256 transfer. It is clear how a number of these services will deliver health benefits. Some examples include:

- Funding for additional home care hours which is supporting a reduction in delayed transfers from hospital
- License costs, data input and analysis for the CareTrack system, which is starting to provide very valuable information across the health and social care system to inform activity planning and financial modelling
- Dedicated resource to work with partners in Adult Social Care and Health to support families who are experiencing issues around drug and alcohol misuse

The BCF plan meets the template criteria and is therefore rated GREEN for completeness. We have rated it AMBER for quality because the explanation for which social care services will be protected, and how this will deliver health benefits, could be pulled out more strongly within the main body of the template. At the moment the narrative in the template it light, with all the detail contained within Annex 1.

Recommendations for improvement for Leeds plan

3. Leeds should include more information in the main body of the template about the social care services BCF funding will be used to protect, and how this will deliver health benefits. This will tighten the structure and provide additional clarity and explanation to the reader.

2.2.4 Seven day services in health and social care

What the template requires

The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources. In the BCF, local areas are asked to provide evidence of a strategic commitment to providing seven day health and social care services and describe agreed local plans for implementing seven day services to support patients being discharged and prevent unnecessary admissions at weekends.

A "great" BCF plan will include:

- Clear evidence of a commitment to 7 day working
- Clear explanation of which services will work 7 days as a result of BCF funding
- A timeline and implementation plan for moving towards 7 day working in these services

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan states that *"moving health and social care services from five to seven days is a key commitment across the health and social care system….Leeds already has a 24/7 community nursing and care management service. The BCF offers the city an opportunity to build on this"*.

The Leeds plan explains that the BCF funding will target seven day working, particularly in relation to the community beds and enhance integrated neighbourhood teams schemes. Operational changes will include:

- The community bed bureau would move to 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 to service users
- The plan also states that a core requirement of the 14/15 contract with all main NHS providers is to work with commissioners to facilitate the delivery of seven day working requirements

We have rated the Leeds plan as GREEN for completeness because it provides clear evidence of commitment to seven day working and describes the services which the BCF will fund to move towards seven day working. We have rated the quality as AMBER because there is no clear implementation plan or timeline included. Stakeholder discussions have revealed that this is in the process of being developed.

Recommendations for improvement for Leeds plan

4. Leeds should progress with ongoing work to develop a timeline and implementation plan for seven day working, understand the cost of moving to seven day service and the potential savings from operating uniformly during the week. This would add a further level of detail and clarity to the plan.

2.2.5 Better data sharing based on NHS number

What the template requires

One of the national conditions of the BCF is that plans support better data sharing between health and social care, based on the NHS number. The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe and seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information.

The template requires local areas to:

- Confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to
- Confirm that they are pursuing open APIs (i.e. systems that speak to each other)
- Ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

A "great" BCF plan will include:

- Commitment to the three required areas listed above; NHS number, open APIs and IG controls
- Evidence of ambition to move beyond using NHS number towards a single record system

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan meets all these requirements by confirming that:

- The NHS number is being used as the primary identifier across health and social care and NHS numbers are "traced" and added to the patient/client record as early as possible.
- Adopting systems that interoperate is a key part of a formal Leeds-wide Informatics strategy and progress is being made towards delivery. Leeds is committed to working with Open APIs, however cost is a factor and the cooperation of system suppliers is required. 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.
- Leeds is 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. Leeds 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 arrangements in place. The resource required to strengthen multi-organisational IG expertise is included n the proposed BCF Informatics scheme.

Leeds has an ambition to become a digital city and has gone above the informatics requirements of the BCF in a number of areas. The Leeds Care Record allows all relevant practitioners within the system to see real-time data on individuals at the point of service delivery. Leeds are working closely with the Department of Health to look at national legislation which can improve data sharing, for example the recent section 251 application being pursued for risk stratification using health and social care data. Leeds is also focused 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 decision in line with people's experiences of care, leading to better outcomes.

Recommendations for improvement for Leeds plan

None

2.2.6 Joint approach to assessments/single accountable professional

What the template requires

When integration is discussed, one area which often arises is joint assessments and a robust approach to care planning. A national condition of the BCF was that plans should *"Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional"*.

The BCF template requires areas to confirm that 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. Areas are also asked to specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification has been used to identify them and what proportion of individuals at risk have a joint care plan and accountable professional.

A "great" BCF plan will include:

- Description of a robust risk stratification tool and what actions are taken when someone is identified as "at high risk of admission"
- A statement of what proportion of the adult population are identified as at high risk of hospital admission
- Clear explanation of future process for completing joint assessments, personalised care planning and allocating single accountable professionals

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan specifies that Leeds has a well-established system of risk stratification already in place to identify patients at high risk of hospital admission. 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.

This 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. New arrangements for GP contracting mean that the tool will now 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 specify a care coordinator, 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.

A CQUIN has also been in place since April 2014 which incentivises Leeds community health services to work in a more interdisciplinary way with primary care, to deliver improved proactive care management.

The Leeds BCF plan meets all the requirements of the template and the criteria for a "great" plan so has been rated GREEN.

Recommendations for improvement for Leeds plan

None

2.2.7 Agreement on consequential impact in the acute sector

What the template requires

The original aim of the BCF was to enable more investment in integrated community services and thereby reduce acute activity and expenditure. This is in line with government policy about delivering care close to home and would meet patient and service user expectations about their care. However, it also has the potential to destabilise providers and, as a result, the template requires areas to articulate the implications of BCF plans on the acute sector.

The template asks:

- You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising
- What is the impact of the proposed BCF schemes on activity, income and spending for local providers?
- What is the local acute trust's view of the plan?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here

A "great" BCF plan will include:

- Evidence that acute providers are signed up to the BCF plan
- Evidence that acute plans are aligned to the BCF and its planned impact
- Basic modelling to show BCF impact on acute sector e.g. "if admissions decreased by x% then the provider would lose £y income from the activity"

Our assessment of the Leeds BCF Plan

Completeness	Quality

The plan refers to the risk that realising savings through reductions in hospital activity has for the city, with the possibility that the NHS in the city becomes financially unsustainable and fails to meet service delivery targets.

The plan notes that it is imperative the development of the acute strategy for Leeds is cognisant of the approach of NHS England to specialised service commissioning, given the scale of specialised activity at LTHT.

The Leeds BCF plan describes that LTHT recently consulted on its 5 year strategy, which states its intention to deliver seamless integrated care across organisation boundaries, with a reduction in urgent admissions for frail elderly patients an those with long term conditions by 20%.

In Annex 2, in response to the question "can you confirm that you have considered the resultant implications on your organisation" LTHT state "Leeds THT understands the overall objective and impact of the BCF programme and recognises it as an important component in achieving financial sustainability for LTHT and the Leeds health and social care economy. However, we have not yet modelled clinical strategy at a sufficiently granular level to determine the precise implications. This work will take place over the next 6 months as clinical business strategies are developed".

The plan is rated RED for both "completeness" and "quality" because it meets less than 75% of the template requirements and the points required for a "great" plan. This is due to the lack of modelling and quantification of the potential impact on the acute.

Recommendations for improvement for Leeds plan

5. Leeds rapidly needs to progress work to quantify the impact of the BCF on LTHT and ensure that this is taken into account in the Trust's plan.
6. Leeds must develop a robust contingency plan for a scenario in which these savings are not delivered.

2.2.8 Proposed schemes are locally relevant

What the template requires

In defining a vision for health and care services, local areas are required to draw on the JSNA, JHWS and patient and service user feedback to identify the health and social care services most in need of integration. This should inform the changes that will be delivered in the pattern and configuration of services over the next five years, and the difference this will make to patient and service user outcomes.

A "great" BCF plan will include:

- JSNA used to identify areas of care that could be improved through integration
- Proposed changes clearly linked to the JSNA and public health needs, so they are locally relevant
- Proposed changes link together to form a clear vision and overarching model for integrated care which addresses these areas
- Clear articulation of the difference this will make to outcomes

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan is clearly based on evidence from the JSNA and JHWBS which identifies the conditions and populations most likely to benefit from integrated care; people with long term conditions, people with complex needs, people over 75, dementia and co-morbidity and hospital admissions for hip fractures. The schemes are linked to these areas and are therefore locally relevant and address local need. This is a key strength of the Leeds BCF plan.

The plan sets out the anticipated outcomes, which link to the BCF metrics and local metrics around dementia diagnosis and the total number of days spend in care/residential home facilities. It is another key strength of the Leeds plan that they have included additional local metrics (above the single metric required) that they consider important for their area.

The vision sets out that the BCF is part of a wider Transformation Programme, but does not clearly articulate the overarching model of care the area is moving towards.

The Leeds plan has been rated as AMBER for completeness because, while the plan broadly contains the required information, it is not well structured and the vision and description of proposed changes is not clear to the reader. The plan is rated AMBER for quality because of the lack of an overarching model of care and clear articulation of how this will deliver the stated outcomes.

Recommendations for improvement for Leeds plan

7. Leeds should link the 22 planned BCF schemes to an overarching model of care. This would help the reader to understand the overarching transformation that is going to take place. Clearly linking the schemes to the outcomes would also support the reader to understand how the new model of care will deliver these outcomes. Examples of overarching models of care that have been used by other areas are included in Appendix B.

2.2.9 Clear implementation plan

What the template requires

2014/15 is designed to be a “shadow year” for the BCF, but there is no requirement for additional pooling of funds. The BCF comes into full effect from 2015/16. The template asks for spend and benefits to be split by year but does not request that a plan of action or implementation plan is included.

A “great” BCF plan will include:

- Implementation plan which sets out key milestones for delivery
- Understanding of critical path to successful delivery which links actions required by all organisations and is signed up to by all stakeholders

Our assessment of the Leeds BCF Plan

Completeness	Quality
NA	

Given this information is not requested within the BCF template, we have rated the Leeds BCF as NA for completeness. However, having a clear plan of action in place is clearly a key requirement for “great” plan in order to provide assurance that plans are in place to successfully deliver the proposed schemes.

The Leeds BCF plan does not include an implementation plan or show evidence that organisations have considered the critical path for successful delivery, linking the actions of all organisations. From stakeholder discussions, we understand that the BCF programme team are in the process of developing these plans, but there were not complete in time for inclusion in this submission.

Recommendations for improvement for Leeds plan

8. Leeds should continue to develop their BCF implementation plan and ensure there is a clear understanding by all organisations of what actions are required, and the critical path to successful delivery. Including this in the BCF plan would provide assurance that plans were in place to implement the proposed changes.

2.2.10 Governance and delivery mechanisms

What the template requires

Effective governance is a key enabler for any large delivery programme, and is especially important for a programme like BCF which involves multi-agency working and financial risk. There needs to be coherent governance and delivery mechanisms in place with clear local management and accountability arrangements.

The BCF template requires local areas to provide details of the arrangements in place for oversight and governance for progress and outcomes.

A "great" BCF plan will include:

- Clear governance structure, supported by a diagram for clarity if required
- Description of a realistic delivery model which describes how BCF will be implemented
- Description of how delivery will be managed and overseen through the governance structure
- Clear understanding of the dependencies within the delivery structure

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan explains that the day-to-day executive leadership and steer for the BCF will be through the Integration 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 governance section of the plan includes reference to a Section 75 agreement for 15/16, with the local authority acting as the pooled budget holder. The plan also includes an agreed process for developing all transformational changes in the city.

The Leeds BCF plan is rated AMBER for completeness and quality in relation to governance because while a number of boards and groups are referred to, it is not clear from the text how these link into a governance structure. Stakeholders have shown us a diagram which sets out the governance for the Transformation Programme and how the BCF fits into this. Including this diagram, or a similar version focussed on BCF, in the plan would be very beneficial. The plan does not contain any information about how these boards will carry out their governance role e.g. the information and accountability flows. The plan does not set out a delivery model, although this is clear in the diagram we have seen so could be address by its inclusion.

Recommendations for improvement for Leeds plan

9. Leeds should include a diagram explaining the governance diagram in their BCF plan, which clearly sets out accountability flows. The diagram should also be clear who is responsible for delivery. This could potentially be done very clearly through a RACI, which sets out the accountability and responsibility of each group. It would also be beneficial for Leeds to include an explanation of how the various groups will oversee and manage implementation e.g. frequency of meetings, information they will be provided with.
10. Leeds should undertake a dependency mapping exercise to clearly show the interdependencies between the workstreams in their delivery structure.

2.2.11 Quantification of benefits and benefits management

What the template requires

Good practice benefits management is clear that benefits have to be accurately quantified and understood, with clear mechanisms in place to track the impact over time to ensure benefits are being realised as anticipated. Contingency plans need to be in place which can be implemented if benefits are not delivered.

For each scheme, the BCF template requires local areas to define the benefit that it will deliver, how this will be achieved, and which organisation the benefit will from its delivery. The template requires organisations to state the activity change against 13/14 outturn and trend that will result from each scheme and calculate the financial value of this based on a unit cost.

The template contains a box to explain "how will the savings against plan be monitored".

A "great" BCF plan will include:

- Benefits of each scheme clearly quantified
- Evidence that a robust benefits management framework is in place, with named people against each benefit
- Evidence that a robust contingency plan is in place

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF scheme has only quantified benefits for five schemes. From our stakeholder discussions it is apparent that calculating benefits for each scheme at this level of detail has been very challenging for a number of reasons including:

- It is not possible to consider the schemes in isolation; they will work together to achieve an overarching level of benefit. Individually some schemes would not deliver a benefit because they are enablers e.g. the equipment service being available 7 days a week which will allow community teams to care for people at home and discharge people over the weekend
- The template is very rigid and inflexible, so even if the business cases for schemes had been finalised and the benefits fully understood, it would not always be possible to fill in the information in the defined way

Suggested changes to the template to address these points are explored in section 3.

The Leeds BCF plan does not include any information in the column "how will the savings against plan be monitored". A contingency fund of £1.9m is included within the plan in case activity in the acute does not reduce as planned. If activity levels decrease as anticipated, this money will be used to fund further schemes in 15/16.

The plan has been rated RED for completeness and quality of benefits, because less than 75% of the template requirements and criteria for a "great" plan have been included.

Recommendations for improvement for Leeds plan

11. Leeds need to continue work on developing business cases for the BCF schemes and finalise these ASAP to quantify the benefits. Leeds need to develop a robust benefits management framework and this should be included in the plan. Examples can be found in appendix E.

2.2.12 Risk management

What the template requires

Effective risk management is vital for any complex programme to ensure risks are identified, their impact is understood and appropriate mitigations are put in place.

The BCF template requires areas to provide details of the most important risks and the plans in place to mitigate them. This should include the risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

A "great" BCF plan will include:

- Risk log is completed with all key risks
- Robust mitigation actions are in place so that residual risk is at an acceptable level

Our assessment of the Leeds BCF Plan

Completeness	Quality

The Leeds BCF plan includes a comprehensive risk log which covers a range of risks. It includes a "risk rank" (very high – medium) , how likely the risk is to materialise (probably, possible or unlikely), a description of the potential impact and mitigating actions.

The plan is rated GREEN for completeness of risks, because the risk log template has been completed as required. However, we have rated it AMBER for quality because the two risks ranked "very high" are also ranked as "probable" for the risk materialising. This suggests that the mitigating actions are not sufficient to manage the risk appropriately.

The template does not currently ask local areas to state the residual risk. We have included a possible alternative structure for the risk log table in appendix H.

Recommendations for improvement for Leeds plan

12. Leeds should review their mitigating actions to ensure they are sufficient to manage the impact and likelihood of the risk, and that the residual risk is acceptable.

2.2.13 Triangulation with other plans

What the template requires

The template asks local areas to explain if local providers' plans for 2015/16 are consistent with the BCF plan. However, there is no mention of triangulation with other plans that are in place, such as CCG two year operational plans and the five year strategic plan, or the local authority targets for the adult social care outcomes framework.

The Better Care Fund is not isolated from the wider system, and as a result it is vital that the plan aligns with these other plans that have been developed.

A "great" BCF plan will include:

- Clear articulation of how the BCF plan aligns with 1) the provider plans 2) the CCG two year operational plans 3) the CCG five year strategic plan and 4) the local authority plans which set out targets for the adult social care outcomes framework.

Our assessment of the Leeds BCF Plan

Completeness	Quality
NA	

The Leeds BCF plan alludes to the fact that the acute provider plan is aligned, although more work is needed to ensure this filters down to the clinical business strategies as they are developed.

The plan does not mention the CCG two year or five year plans, or any local authority plans. However, discussions with stakeholders suggest that plans are aligned due to close co-production that has taken place, but this is not evidenced or mentioned within the document.

Recommendations for improvement for Leeds plan

13. Leeds should include a short section within their BCF plan which articulates how all the different system plans are aligned and take into account the anticipated impact of the BCF.

2.3 Local insight on deliverability

Through-out our deep dive review of the Leeds BCF plan we have engaged with a number of stakeholders from West Yorkshire LAT, the three CCGs in Leeds and Leeds City Council. A full list of who we have engaged with can be found in appendix A. These conversations have provided us with local insight about deliverability of the Leeds BCF plan and the challenges for implementation. The points raised by the Area Team and the local multi-agency BCF programme team related to deliverability are included below.

Views of the Local Area Team

- There are a **large number of schemes** in the Leeds BCF plan and the LAT are concerned that trying to focus on too many things at once is a risk to delivery
- The **Transformation Programme has a complex structure** with multi groups. The LAT are concerned that the number of meetings and complex web of dependencies is a risk to delivery and people will spend "too much time discussing things and not enough time doing things"
- Leeds **does not have a strong track record** of delivering change. For example, investment in the community sector to date has not led to bed reductions in the acute sector
- Leeds Community Healthcare NHS Trust is quite a small organisation and there is **concern about their capacity to pick up the activity** transferring out of the acute at the pace and scale required
- Benchmark data suggests there is **scope for LTHT to decrease admissions** – this target should not be any easier or harder to achieve than it is for other Trusts

Views of the Leeds BCF Programme Team

- The programme team are **confident in their plan** and, whilst recognising that it will be challenging, are **confident in their ability to deliver it**
- Strong view that they **need to stop rewriting the plan and start delivering** it and implementing the schemes
- Isolating the BCF from the wider Transformation Programme is not possible and trying to do this takes the focus away from the bigger picture. **The BCF is £55m of a total £1.5b spend and must be seen as part of this wider change**. The BCF alone will not deliver the changes required
- The team are in the process of **developing the business cases** for proposed schemes and this will provide the insight needed about the benefits that will be delivered
- Health and social care organisations have very **strong working relationships** and are committed to achieving best value for the Leeds £. Organisations are moving towards open book accounting
- Leeds have been working on their Transformation Programme for longer than the BCF has been in place and are **well organised and mobilised**

2.4 Challenges to implementation

Our conversations with stakeholders have also provided insight into the challenges to implementing the BCF. The views of stakeholders about the challenges for implementation nationally and locally are described below.

Challenges for implementation nationally

- The BCF process for developing and assuring plans has taken a significant amount of resource. The **continuation of the planning process is a challenge to implementation** because areas cannot focus on delivery whilst continuing to rewrite their plans.

  "The BCF process itself will have contributed to the slippage of the process" – Leeds BCF programme team member

- **Developing the Section 75 agreement** and formalising the governance around the BCF will be costly and time consuming. A question has been raised as to whether NHS England will be issuing a template so local areas do not have to develop these from scratch at their own time and cost.

- The **aim of the BCF keeps changing** and this puts a strain on organisational relationships e.g. the new guidance which offers protection to the NHS and moves away from the original focus of protecting adult social care and using these services to deliver health benefits

- **Continually shifting goal posts** makes it difficult to move towards delivery due to lack of certainty about whether this is the final position e.g. organisations unable to recruit staff to enable transformation without long term certainty of policy direction and funding

Challenges for implementation in Leeds

- **Leeds do not have a timeline for implementation or understanding of their critical path**

- The **new policy around payment for performance** and 3.5% reduction in emergency admissions means the size of the Leeds contingency fund will need to increase. This means that **less "pump-prime" money will be available to invest in schemes**. The impact of this on delivery of schemes is not yet fully understood

- Discussions about **risk sharing agreements are only at early stages** but these agreements need to be in place for implementation

- No developed understanding about the **impact of the Care Act** in Leeds

- There is a lot going on in Leeds and the Transformation Programme is complex. **Understanding and managing the interdependencies** is vital.

Section 3

Review of the revised BCF templates

3.1 Recommendations on the BCF templates

Feedback on the new BCF templates

The following feedback and observations were collected through the course of our engagement with stakeholders in Leeds.

Narrative template

► Some of the key lines of enquiry set out in the Invitation to Tender document focus on areas not reflected in the BCF template questions. If these are areas which are the current priorities, the template needs to be updated to reflect this and ensure the questions focus on the main areas of importance. We recommend a review of the template questions in order to ensure that they elicit the required information.

► The majority of template questions have multiple components, which leads to potential lack of clarity and concision in responses. For example, section 3d "Joint Assessment and Accountable Lead Professional" which asks *"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 asses 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 lead professional".* We recommend splitting some of the multi-component questions into stand alone sections.

► The current Annex 1 template has some questions duplicated and some questions are difficult to address due to the range of information requested. For example *"Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (included references*)". In addition, some key relevant information is missing e.g. how the scheme supports delivery of the national conditions and the key performance indicators and how they will be tracked. We have included a recommended alternative template in appendix G. This is structured as a summary business case which means that not only will it elicit the key information on schemes, but can serve a dual purpose because local areas will need to produce business cases for BCF schemes for their own internal sign off.

► The risk log should include a net and gross risk assessment of potential impact to reflect efficacy of the mitigating action. We have provided an example of a good practice risk log in appendix H.

► The template could be improved further by prompting the BCF site to clearly distinguish between the genuinely new schemes and the existing schemes that will now be bought in as BCF schemes. This information could be gathered through section 2b, where local areas are required to list their planned changes.

3.1 Recommendations on the BCF templates

Financial template

► The inclusion of two financial templates is seen as duplication and potentially divisive. Asking areas to separate each organisation's financial commitment to schemes seems to be at odds with the ethos of the BCF which is driving towards pooled funding/single budget. It is also considered potentially harmful to relationships because it introduces separation when it should be driving towards collective working, for example in Leeds where the system is moving the Leeds £. It is recommended that the BCF only uses one (HWB) template.

► The financial template now requires a significant level of granularity about the benefits of each scheme, and completing this level of detail was deemed by Leeds to be very difficult. This is because it is not possible, and indeed unhelpful, to consider the benefits of each scheme individually when they act together to deliver the benefits – "*the whole is greater than the sum of the parts"*. For example, Leeds are proposing to extend their community equipment service to seven day working using the BCF. However, this on its own will not deliver any benefits. The community teams and discharge facilitators also need to work seven days a week and together they will deliver a benefit. We recommend that a methodology is provided to help local areas model benefits at the required level of granularity. However, we also recommend that some pragmatism is required about the level of benefits that local areas are going to be able to calculate within the timeframes, and make the template less restrictive so that benefits can be entered in different formats depending on the information available locally and the benefits schemes will deliver.

► The drop down menus on the financial template are currently too limited for local areas to be able to provide a good explanation of each scheme. For example, some of the Leeds schemes already span a number of "areas of spend" and are jointly commissioned or provided. Leeds selected "other" for a large proportion of their schemes because they did not fit into the boxes provided. We understand from NHS England that areas were supposed to include multiple lines to cover this. This is not clear in the template and would require expenditure to be broken down within schemes. We recommend that the drop down boxes are expanded to provide options around "jointly commissioned" and "jointly provided".

► We understand that some figures within the finance template were pre-populated and there were questions about whether or not this data was correct. We recommend that an explanation of any pre-populated data is provided and that any prepopulated data is not locked down, so that local areas can update it if required.

► The Leeds BCF Programme Team has suggested that a performance indicator based on total acute bed days could be a better reflection of the effectiveness of the BCF, rather than emergency admissions. This is easier to attach a value to and also encompasses improvements in length of stay and delayed discharges through better integrated working in the community.

► The template should capture the assumptions made in devising the benefits attached to schemes, as well as the basis on which the scheme will achieve the required effect on EM admissions. This will help those assuring the plans to understand the basis of the calculations and reduce the need for clarification. This information could be collected in the column headed "how was this saving calculated?" if the information was explicitly requested.

3.2 Recommendations to take the new payment for performance guidance into account

Recommendation for Baseline

The table below covers the key advantages and disadvantages of some potential baseline measures for the Reduction in Emergency Admissions metric

Baseline Method	Advantages	Disadvantages
13/14 Outturn	Readily available and signed off	Demographic change is not factored in so the BCF would be being measured against a target that does not take into account uncontrollable factors
14/15 Forecast Outturn	Most recent information Reflects planned 14/15 trend and demographic changes (as set out in planning rounds)	Forecast outturn would differ depending on the entity – i.e. the CCG could have different view of the number of EM admissions than the provider – which view is more appropriate? Relies on accuracy of projection
Rolling 18 Month		Would mean that BCFs are being measured against historic standards that are no longer relevant
14/15 Forecast Outturn adjusted for Demographic change	Would be the most up to date and forward looking target baseline Removes the potential of demographic change masking the true effect of BCF, e.g. negative demographic change unaccounted for in the baseline would mask less successful schemes	Some demographic change is subjective and some BCF sites may disagree with the standardised adjustment

Our Recommendation	As an outcome of our conversions with key stakeholders, we recommend using 14/15 Forecast Outturn adjusted for demographic change as the baseline for establishing the payment for performance target. This method allows performance to be measured against targets that already account for natural changes in admission rates, meaning a truer reflection of BCF performance can be obtained. Prescribed demographic statistics (likely to be provided by ONS) are already used by CCGs as part of their annual operating plans and guidance should direct areas to suitable datasets

3.2 Recommendations to take the new payment for performance guidance into account

Changes to Template

- We recommend including a new section in the Finance template which provides a demonstration of the real impact of the target reduction in emergency admissions, and is interactive to allow the local area to explore different target levels.
- The spreadsheet should be pre-populated with the total payment for performance value for the relevant area. The local area will be required to input their planned reduction in emergency admissions in either activity terms or as a percentage. The spreadsheet will then calculate the impact of this reduction on overall activity, the value of the reduced activity, and how it would impact the payment for performance pot.
- In displaying this information, the template will take steps in ensuring that the BCF site is aware of the impact of their target and can plan accordingly
- Stakeholders in Leeds have also suggested that the Payment for Performance target be set out on total acute bed days rather than emergency admissions.

The box below provides an indication of what the new section within the Finance template would look like

Using xx/xx as Baseline

Payment for Performance Value:	£250,000
Value placed on EM admissions:	£100
Please provide ONE of the following:	
Planned Reduction in EM Admission (%):	3.5%
Planned Reduction in EM Admission (Activity):	

Baseline (Activity)	Target Reduction	Targeted Reduction in EM Admissions (Activity)	Value of Reduction Target	Value to be returned to NHS Commissioning Services
15,143	3.5%	530	£53,001	£197,000

Section 4

Suggestions for inclusion in the assurance process

4.1 Suggestions for inclusion in the future assurance methodology

Assurance process

Below, we have summarised the feedback from NHS West Yorkshire Area Team on the previous assurance process:

What worked well

- WYAT provided proactive support to all BCF areas during the template completion process, to provide assistance with the interpretation of the technical guidance, which ensured that all areas within the WYAT area of responsibility were given consistent information and advice.
- WYAT adopted a collaborative approach to assurance, using a team of four people from across the organisation to assure each Plan. This lead to each Plan being reviewed from a range of different points of view e.g. Finance, Strategy, Operations, Assurance, in order to arrive at a holistic assessment of the Plan.
- Plans were mapped on to a nine-box model to provide a simple overview of their quality and deliverability and allowing comparison across the WYAT area of responsibility.
- The team used the assurance framework which was centrally provided but extended the RAG assessment to include comments to record strengths and weaknesses of each Plan.
- The Peer Review process was highly beneficial as areas could use the opportunity to learn from each other

What could have worked better

- Leeds BCF programme team reported that the feedback that was provided highlighted the gaps in their plan but did not provide guidance on how these could be closed
- Reissuing of templates and guidance during the completion process caused delay and confusion
- There was too much room for interpretation in the guidance, leading to many clarification questions

Guidance and tools

The successful completion of the revised round of BCF Plans relies on the provision of clear, explicit guidance in addition to the sharing of exemplar Plans. This will minimise the risk of poorly completed Plans being submitted in the next planning round, and allow for a more consistent assurance process.

This guidance should include:

- Key changes to the Plan template since the previous version
- A comprehensive description of what 'good' looks like, which can be directly mapped to the assurance framework which will be used
- Clear and simple technical guidance which leaves no room for interpretation

The guidance should be supported by the Webinars or similar training tools.

To be successful, it is recommended this guidance is accompanied by a range of tools which areas can choose to use to support the development of their revised plans:

- 'What good looks like' benefit measures e.g. Outcomes Based Accountability
- Examples of benefits models e.g. Total Place budgets, Whole System or BCF Profit & Loss account
- Performance monitoring and P4P tracking model/dashboard
- Examples of risk sharing arrangements between Commissioners and Commissioners and Providers
- Provision of benchmarking for measures/ financial benefits expected/ financial benefits achieved

The proposed assurance process

Desktop review → **Rating** → **Peer challenge** → **Final decision**

Detailed review of submitted plan measured against the assurance framework

Detailed review of submitted plan measured against the assurance framework

Facilitate challenge session between two comparator areas

Assure Plan or provide gap analysis of where further work is required

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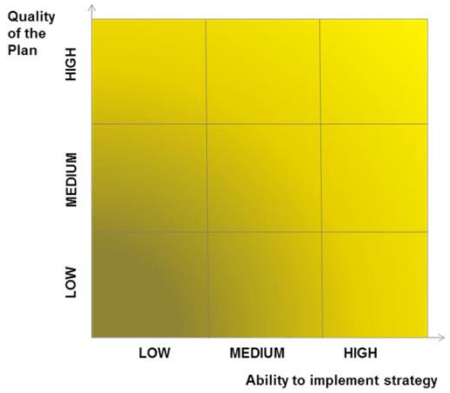
		Confidence that plans will deliver national conditions					
		Plans jointly agreed	Protection for social care services (not spending)	As part of agreed local plans, 7 day working in health and social care	Better data sharing between health and social care, based on the NHS number	Where funding is used for integrated packages of care, there is an accountable professional	Agreement on consequential impact of BCF plan on the provider sector, including consultation with providers
LA Code	**HWB name**	R/A/G (type "R","A" or "G") - see info below table					
E06000019	Herefordshire, County of	G	A	A	G	A	R



4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
1. Plan details a) Summary	Which organisation(s) are completing this submission?	• Signatures from senior representatives of each organisation • Signed-off by Health & Wellbeing Board, including date of meeting which approved the Plan and hyperlink to minutes of the meeting • Evidence of meaningful engagement with providers which has allowed them to input into development of BCF plans • Evidence of strong working relationships across organisations • Value of 2015/16 BCF is at least equal to the minimum required value
	Have all organisations signed-up to the Plan?	
	Is the stated BCF value at least the minimum required value for the area?	
Plan details b) Service provider engagement	Are the key providers clearly identified?	• Clear understanding of who the key providers are and description of how they have been engaged in the Plan development
	Are the providers party to the Plan?	• Description of how providers will be engaged in the development and delivery of the Plan on an on-going basis
Plan details c) Patient, service user and public engagement	Have patients, service users and the general public been involved in the development of the Plan?	• Description of how they have been engaged in the Plan development, such as meetings, forums, involvement of representative groups
	Are patients service users and the general public party to the Plan?	• Description of how these will be engaged in the development and delivery of the Plan on an on-going basis • Evidence of a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
2. Vision & schemes a) Vision for health and care services	Is there a clear strategy for the integration of health and care services, which sets out the areas which are in most need of integration?	• JSNA used to identify areas of care that could be improved through integration • Proposed changes clearly linked to JSNA and public health needs and are locally relevant • A clearly articulated description of the future state of integrated health and social care services for the locality over the next five years, grounded in the JSNA and the JHWS • Evidence base and assumptions which underpin the future state • Proposed changes link together to form a clear vision and overarching model for integrated care which addresses these areas • Clear articulation of the difference this will make to outcomes, with examples of how these will change
	How will the pattern and configuration of services change over the next five years?	
	What difference will these changes make to patient and service user outcomes?	
2. Vision & schemes Aims and objectives	What are the aims and objectives of your integrated system?	• Clear link between BCF aims and objectives and those set out in HWB Strategy and 5 Year Strategic Plans • Articulation of shared commissioning intentions, and how these link to the vision and strategy
	How will you measure these aims and objectives?	• Objectives should be based on SMART principles: Specific, measureable, achievable, relevant and time-bound
	What measures of health gain will you apply to your population?	• Inclusion of a set of existing appropriate measures which will indicate change in the health outcomes of the local population over a five year period • Inclusion of current baselines and five year ambition for each measure
2. Vision & schemes b) Description of planned changes	Summary list of each planned change, to be described individually in Annex 1	• The alternative Annex 1 we have provided in Appendix G includes completion guidance for each question
2. Vision and schemes b) Impact on patient/service user experience	How will each scheme contribute to a change in individual patient/service user experience of health & social care by April 2016 and April 2020?	• Clear comparison between current, 2016 and 2020 state • Use of "Mrs Smith" type story to describe level of change, e.g.

Current	2016	2020
Mrs Smith attends GP to manage her condition	Management takes place at home via nurse	She will self-manage X via technology

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
2. Vision & schemes d) Implications for the acute sector	What is the impact of the proposed BCF schemes on activity, income and spending for local providers?	• Evidence that acute providers are signed up to the BCF plan and agree with the direction of travel • Evidence that the response to this question has been co-developed with relevant NHS providers • Alignment between local providers' plans for 2015/16 and the BCF Plan • The implications of the planned changes for the acute sector • Basic modelling to show potential BCF impact on acute sector e.g. "if admissions decreased by x% then the provider would lose £y income from the activity". • Quantified impact of not delivering the BCF activity on acute sector e.g ability to expand current bed base to accommodate the growth; predicted extra number of required beds which would be required; impact on CCG QIPP performance on acute sector contracts; total system financial impact of non-delivery of the Better Care Plan objective of reduced admissions over in 2016 and 2020
	What is the local acute trust's view of the plan, and to what extent are they involved in developing the understanding of the impact?	
	Are local providers' plans for 2015/16 consistent with the BCF plan set out here	
	What is the risk if savings are not realised?	
2. Vision & schemes e) Governance	What are the governance arrangements which have been put in place to oversee the delivery of the BCF Plan?	• HWB Board has ultimate oversight of the BCF progress and outcomes • Clear governance structure, supported by a diagram for clarity if required • Description of a realistic delivery model which describes how BCF will be implemented • Description of how delivery will be managed and overseen through the governance structure • Implementation plan which sets out key milestones for delivery • Understanding of critical path to successful delivery which links actions required by all organisations and is signed up to by all stakeholders
	What are the locally agreed risk sharing arrangements?	• Agreed local principles to share risk and benefit between commissioners and plans to take this forward into the Section 75 agreement • Agreed principles to share risk with providers which support all organisations to have an appropriate level of risk • Consideration of new contracting mechanisms and organisational forms which would support sharing of risk and benefit

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
3. National conditions a) Protecting social care services	Is there a locally agreed definition of protecting social care services, and what is it?	• The agreed local definition of protecting adult social care services. • How social care services will be protected within the plans • Clarity of which social care services will be protected and to what value • Explanation of how protecting the selected services will deliver health benefits
	What level of resource will be dedicated to carer-specific support?	• Quantified level of resource that will be dedicated to supporting carers locally • Explanation of how these services will help to maintain and promote the independence and well-being of both the carers, and that of the cared for
	How will the new duties resulting from the Care Act be met?	• Quantification of allocation within BCF which is for Care Act against planned activity to prepare for the new duties
3. National conditions b) 7 day services to support discharge	What is the strategic commitment to the provision of 7 day health and social care services?	• Evidence of strategic commitment to providing seven-day health and social care services across the local health economy • Brief description of local plans for implementing seven day services in health and social care • Evidence of a considered approach to pragmatic level of 7 day operation across health and social care • How will these plans impact upon admission prevention and discharge
	What are the local plans which have been developed to implement 7 day working?	
3. National conditions c) Data sharing	Is the NHS number being used as the primary identifier across all health and care services?	• Confirmation that the NHS number is being used as the primary identifier
	Are you committed to using systems based on Open APIs and Open Standards?	• Examples of the systems in place which are based on Open APIs and Open Standards • How the commitment to the use of these has been made
	Are you committed to ensuring appropriate IG Controls will be in place?	• Commitment includes commitment to NHS Standard Contract Requirements, IG Toolkit requirements, professional clinical practice standards • Commitment must reflect compliance with Caldicott 2 requirements
3. National conditions c) Joint assessment & accountable lead professional	Is there a joint process to assess risk, plan care and allocate a lead professional?	• Brief description and evidence of a risk stratification system in place • If accountable lead professionals are not already in place, a clear timetable setting out the route to achieve this across the system • Stated number of how many adults have been identified by this process as being at risk of admission • Stated number of people who have a joint care plan and accountable lead professional
	What proportion of the adult population is identified as being at high risk of admission?	
	What proportion of adults have a joint care plan and accountable lead professional?	

4.2 Suggested assurance framework

Section	Key Line of Enquiry	What 'good' looks like - evidence
Risks	Is there a risk log in place?	• Risk log is completed with all key risks • Robust mitigation actions are in place so that residual risk is at an acceptable level
	If activity is higher than planned, how will this be paid for from within existing resources?	• Quantified contingency pot • Contingency has been calculated using clear analytics and modelling
	What would the financial impact be across the whole system if activity continues to grow at historical trend?	• Modelling showing five year projection • Gap analysis between projects demand and whole system budget

Section	Key Line of Enquiry	What 'good' looks like - evidence
Annex 2 Provider commentary	Do provider(s) recognise the planned non-elective (general and acute) admissions data for 14/15 and 15/16 submitted by the CCG	• Evidence of co-production of the BCF Plan • Clear alignment between the BCF Plan and Provider Business Plans • Triangulation of BCF with CCG planned activity and Provider plans
	Do you agree with the data submitted for the impact of the BCF in terms of planned non elective admissions 15/16 compared to 13/14 outturn and planned 14/15 outturn?	• Confirmation of Provider involvement in developing the BCF Plan • Provider acceptance that the schemes proposed in the BCF will deliver the planned changes
	Can you confirm that you have considered the resultant implications on your organisation?	• Statement of confirmation • Confirmation that Providers are implementing their own risk management and action plans to respond to the planned change in activity • Shared understanding of critical path to successful delivery which links actions required by all organisations and is signed up to by all stakeholders

Section 5

Appendices

Appendix A: Stakeholders we have engaged with

Through the course of our engagement we met with the following people:

NHS England (West Yorkshire)

- ► Elaine Wylie, Director of Operations and Performance
- ► Jonathan Webb, Chief Finance Officer
- ► Louise Augur, Head of Assurance and Delivery

Leeds City Council

- ► Dennis Holmes, Deputy Director, Adult Social Care
- ► Manraj Singh Khela, Programme Manager, Adult Social Care
- ► Steve Hume, Chief Officer, Resources, Adult Social Care

Leeds South and East CCG

- ► Matthew Ward, Chief Operating Officer
- ► Mark Bradley, Chief Finance Officer
- ► Richard Huskins, Head of Commissioning Finance
- ► Tom Mason, Business Intelligence Manager Analyst
- ► Diane Boyne, Commissioning Lead, Community Services and Continuing Care

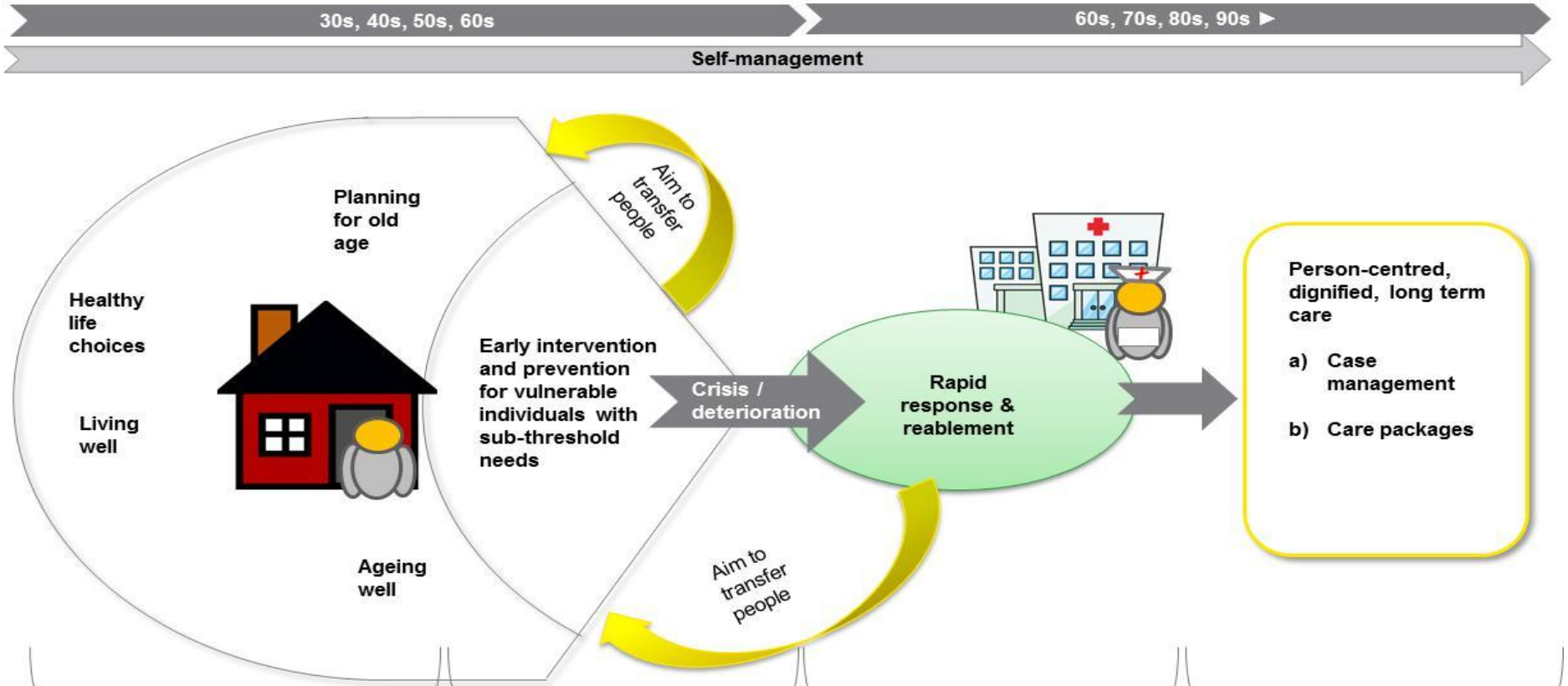
NHS West and South Yorkshire and Bassetlaw CSU

- ► Mark Hindmarsh, Principal Associate for Transformation

The following questions for NHS England were raised during the course of interviews:

- ► What happens next for the exemplar areas – are they required to complete any future template that is issued or are the exempt?
- ► If exemplar areas are to resubmit, will there be any support to complete the recommended improvements to BCF Plans?
- ► What is the new submission deadline?
- ► Will this be the absolute final submission – areas need to put resources into preparing for the BCF implementation, not writing plan templates!
- ► Will there be a national template for the Section 75 Agreement, or will every local area need to pay for legal advice

Appendix B: Example models of care



Components:

- Multi-agency prevention strategy
- Behaviour Change programmes
- Integrated Lifestyle Service
- Planning for older age

Components:

- Proactive case referrals
- Integrated case management
- Community based prevention services
- Digitalisation, adaptations, equipment and housing

Components:

- Pre-ablement
- Rapid response
- Reablement

Components:

- Integrated locality teams
- Joint commissioning of placements
- End of life care

Appendix B: Example models of care cont.

Frail elderly and people who are living with long term conditions

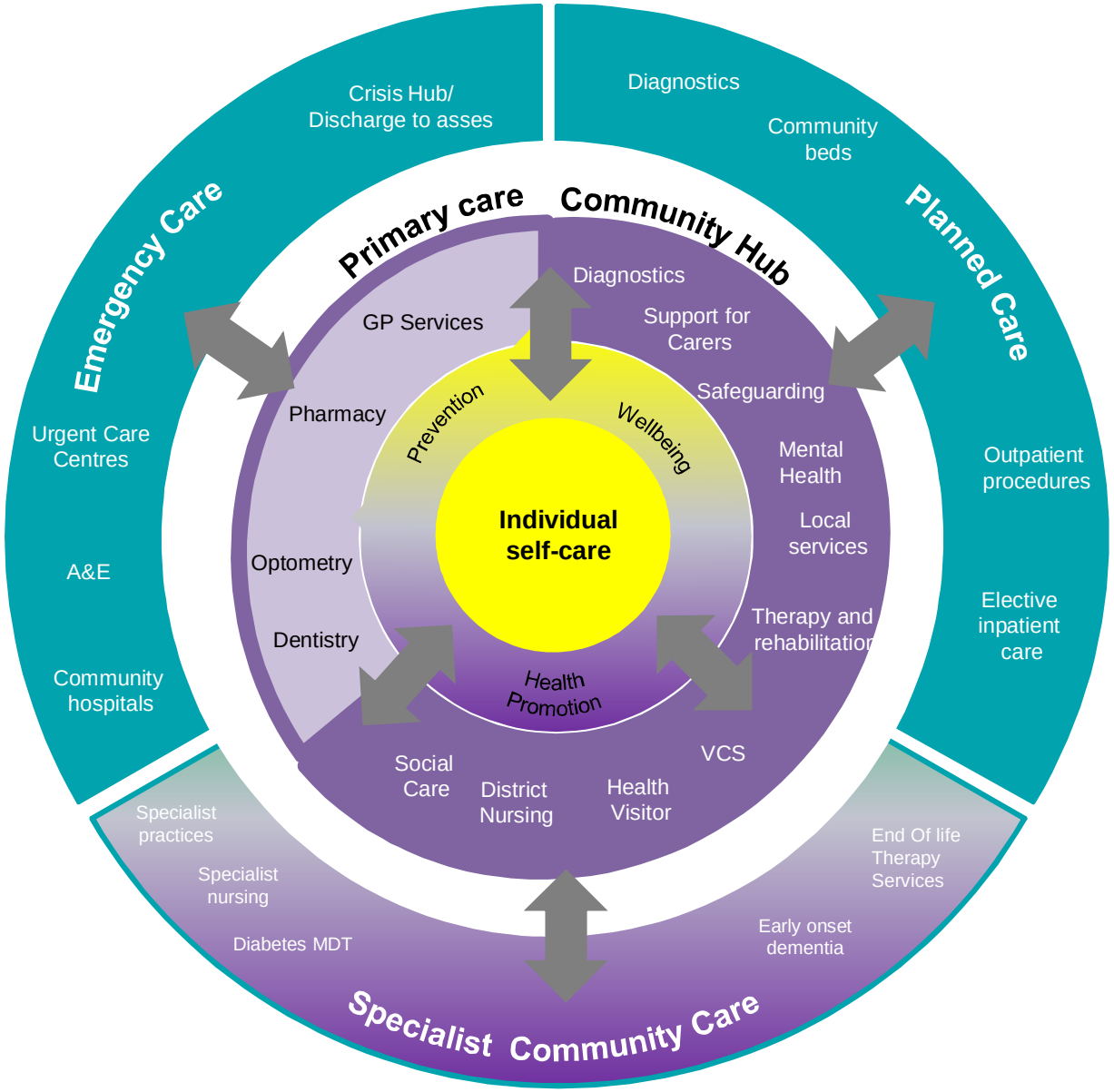
1. Self management

Self management is relevant at all levels across all types of care and support. With all conditions there is a suite of self management interventions which patients/ service users /families can carry out to maintain or regain their independence.

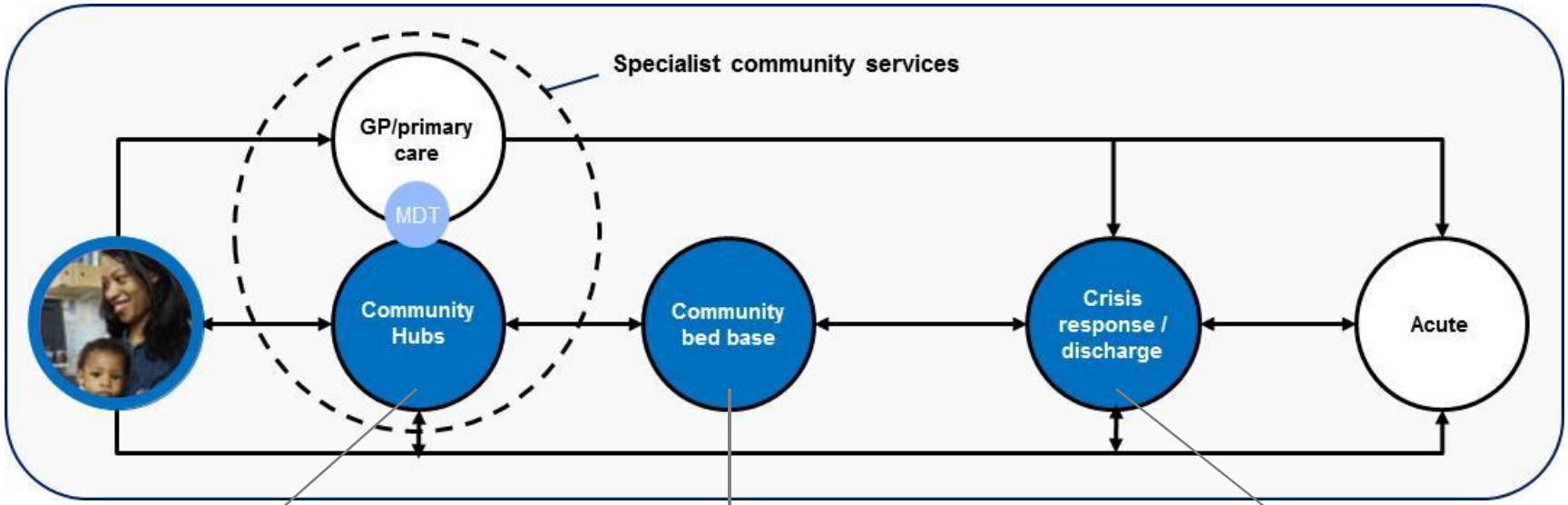
2. Health and well being services	3. Access services including primary care and social care assessment	4. Community based intensive services	5. Residential, nursing and acute services
Health and well being services support people taking responsibility for their own health to help them stay independent of long term services. These services can be accessed universally (above thresholds) and are preventative through initiatives which range from information to intervention.	Access services support a 'no wrong door' model. There is a common entry criteria and risk framework across services and a common process for accessing care through locality teams. Individuals can access a range of services which vary from community based managed by MDTs to urgent care where appropriate.	Community support services increase independence and manage people within the community e.g. at home. These services are provided in the community. They are overseen by multi-disciplinary teams who can move resources around flexibly to avoid crisis and maintain people in their homes or in other care settings e.g. residential care.	Residential, nursing and acute services support intensive care where individuals cannot be maintained at home. These services are drawn on where they are most appropriate and where community based services cannot provide a safe environment in which to receive care.

The end to end system spans from universal services through to long term care with many process steps along each pathway . To structure and group the core elements, this model has been categorised into key components which are depicted within the 5 sections above.

Appendix B: Example models of care cont.



Appendix B: Example models of care cont.



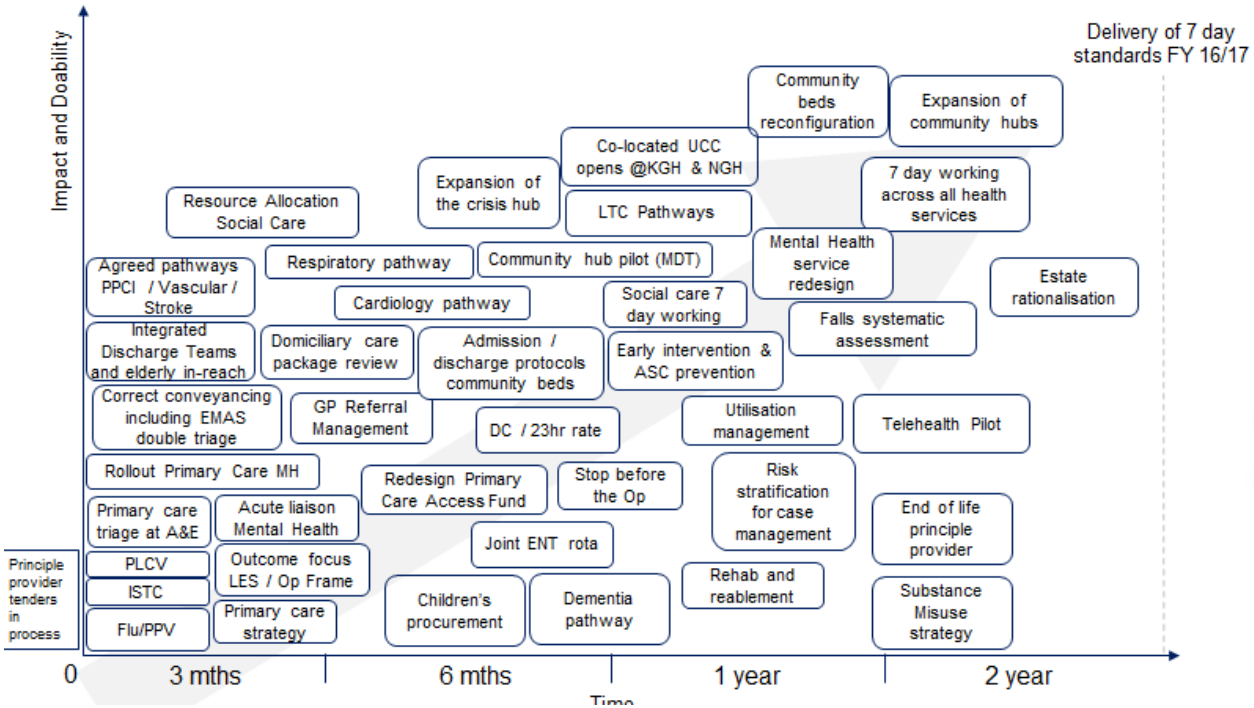
A local single point of access
Information advice and support
GP direct access to a registered practitioner
Adopting an enablement approach with a focus on social prescribing
A holistic assessment of individual's needs
Provision of high quality short and long term personalised support (integrated health and social care services) provided in conjunction with specialist community services
Named professionals providing co-ordinated care
A more generalist workforce - up skilling of staff delivering care and support to get optimal use of resources
Multi-disciplinary discussions focused on individuals at risk

Four types of community beds which have an appropriate level of social care input and decreasing intensity of medical input
Default position that people return to their own home following a stay in a community bed. A relentless focus on planning for this on admission
Focus on self care and prevention throughout an individual's journey

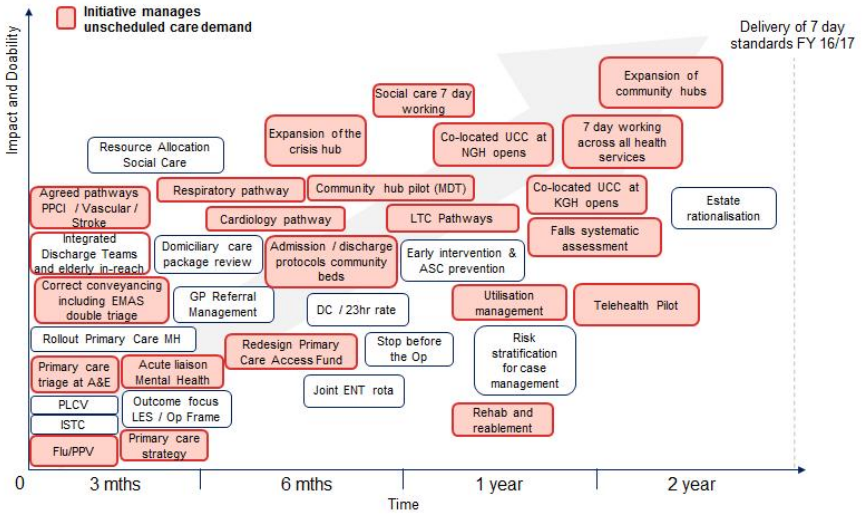
One county-wide crisis service which provides an integrated health and social care response
A focus on preventing hospital admission and facilitating discharge from acute
Existing Health Partnerships teams incorporated into this Crisis team - responsible for in-reaching to acutes and pulling patients out
14 days of intensive support
24/7 service, adults and children's (incl. Mental Health)
Professional referral only

Appendix C: High level implementation plans

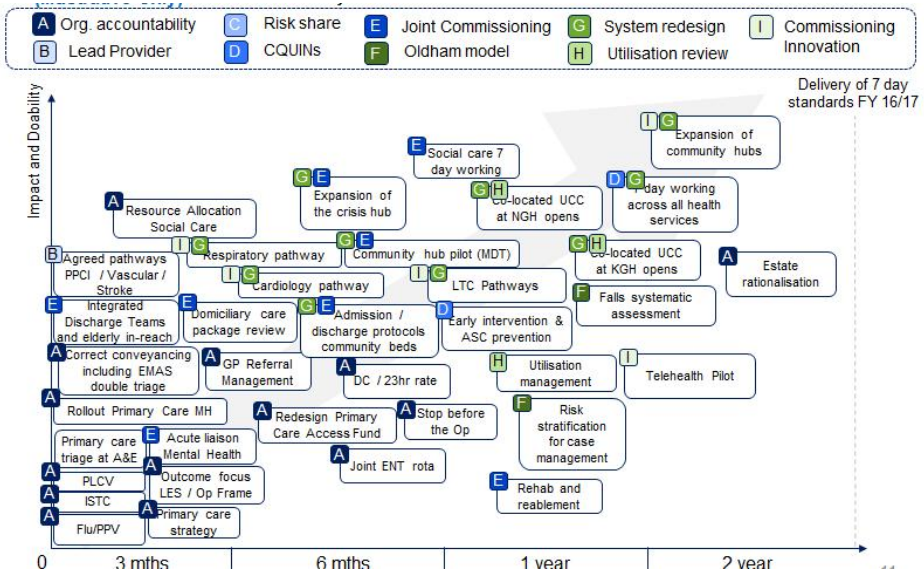
Showing implementation over the next two years



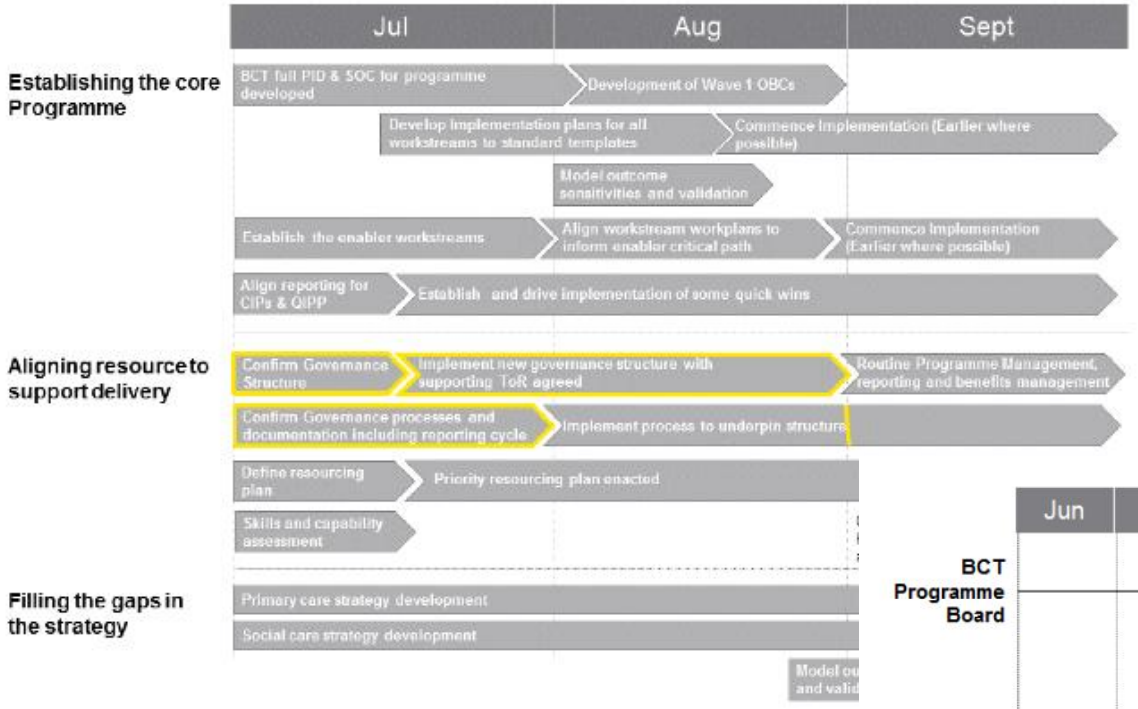
Highlighting the critical path



Highlighting who is responsible for delivery

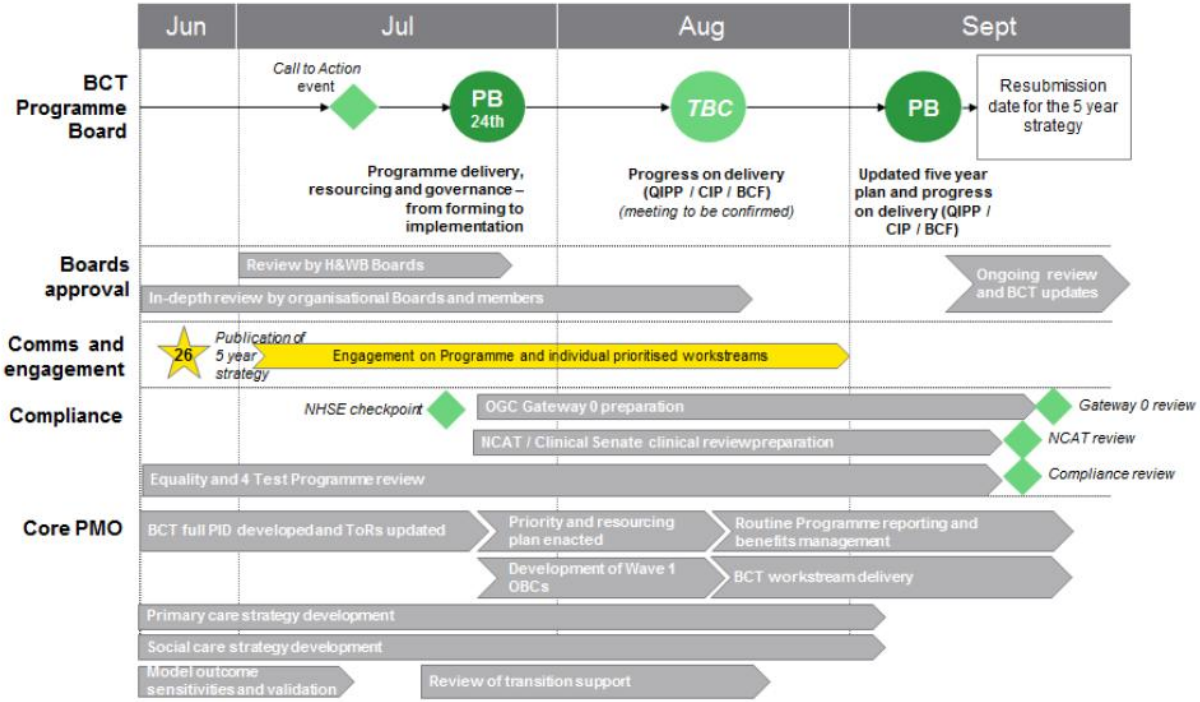


Appendix C: Example implementation plans cont.

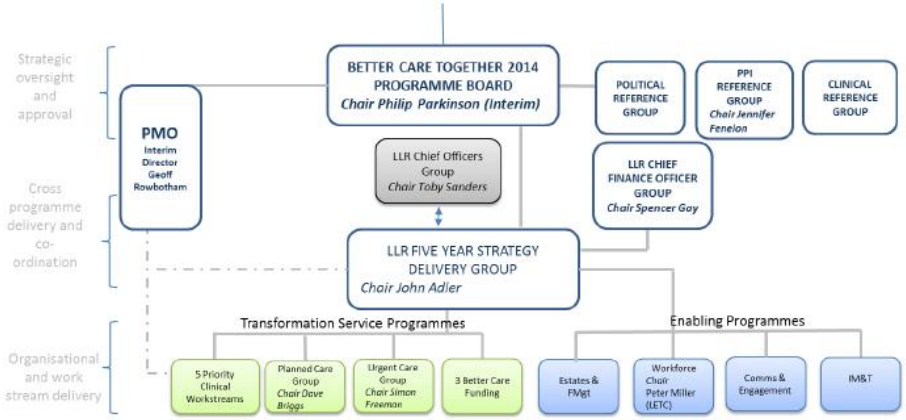


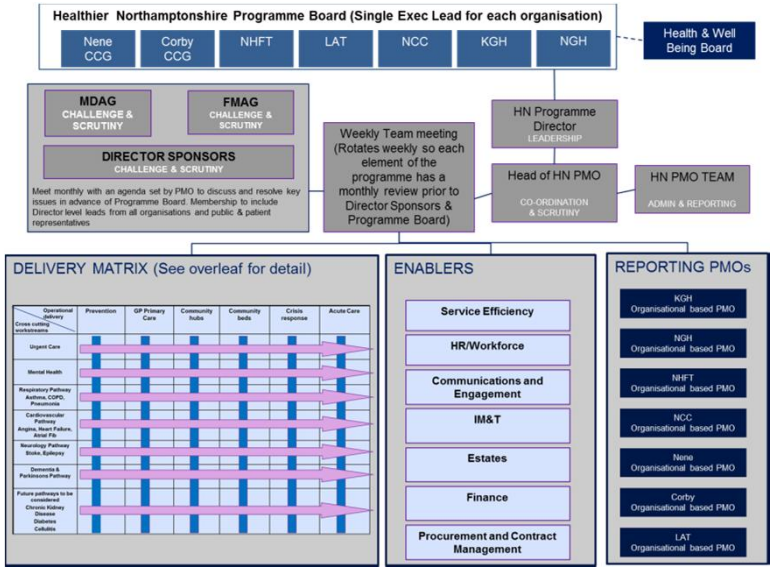
High level implementation plan

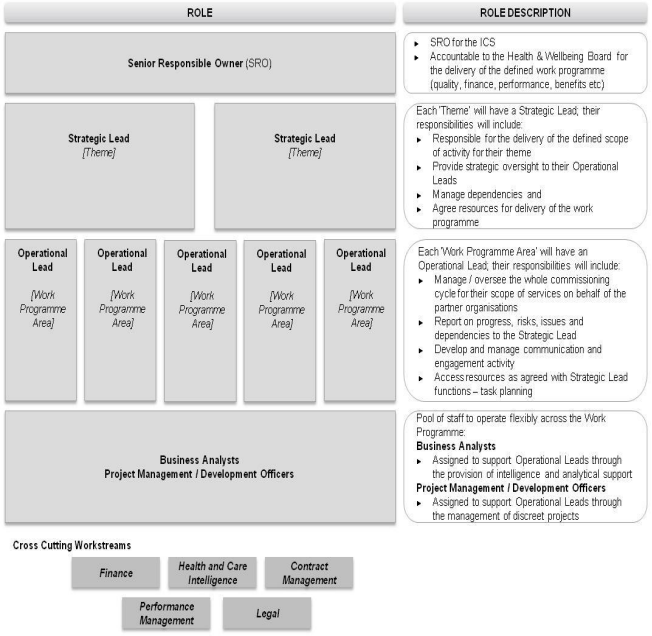
High level critical path

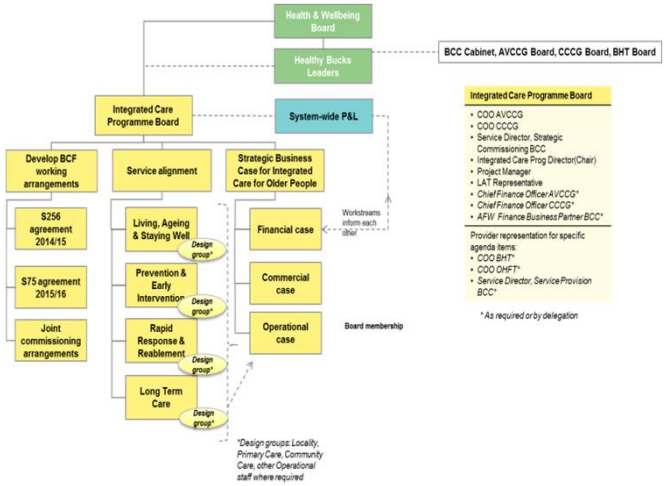


Appendix D: Example governance diagrams

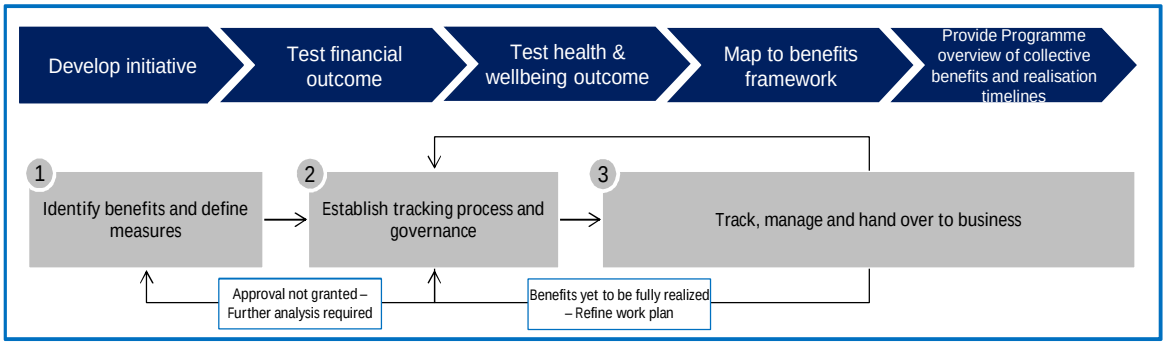








Appendix E: Example benefits frameworks



Benefit	Description	
To achieve better clinical outcomes, patient experience and clinical sustainability by concentrating clinical capability and optimising volumes of activity	• Outcomes – improved outcomes to clinical care. • Patient experience – the patients have a positive view of their experience of clinical care received, including the healthcare environment • Clinical sustainability – compliance with NCAT requirements, CQC etc • Clinical capability – able to provide the best mix of clinical staff to ensure a high quality of care	
	Potential dis-benefits	• May lose more business than planned to adjacent Trusts / independent sector. • Patient travel distance to service may adversely affect the patient overall experience
	Actions necessary to realise benefits	• Development of a robust plan to implement new models of care • Close cooperation and synchronisation with related services in the community, including primary care • Continuing commissioner support • Support from clinical and nursing staff.
	Timescale	• The majority of benefits will be realised within 1-3 years of FBC approval
	Performance indicators	• Service continuity and quality levels • Clinical audits • Positive reports from NCAT, CQC etc. • Length of stay
	Lead director(s) responsible for delivering benefits	• Chief Executive • Divisional Directors / Clinical Directors • CSS Group members

To achieve better clinical outcomes, patient experience and clinical sustainability by concentrating clinical capability and optimising volumes of activity					
Performance Indicator	**Method of Measurement**	**Measure reference**	**Measure**	**Timescale**	**Responsibility for monitoring**
Lower re-admissions	Re-admission rate	1.	▪ Re-admission rates are below level to avoid penalties	4 years from FBC approval	KMS
Implementation of new patient pathways within set time scale	New pathways operational	2.	▪ Project monitoring reports ▪ New commissioning structures in place	2 years from completion of capital developments	CSS group Divisional Directors Clinical leads
Sustainable clinical services	NCAT Audit	3.	▪ Positive and supportive comments from NCAT review	2 years from completion of capital developments	CSS group Divisional Directors Clinical leads

Appendix F: Example risk logs

Key Risks (as per Risk Register)

Ref.	Status	Risk	Description	Impact	Likelihood	RAG Status *(auto update)*	Risk Owner	Mitigating Actions	Action Owner	Due date for actions	Progress update on action
LLR1	Open	There is a risk that if a whole system model is not agreed by the LHE then the impacts across each organisations will not be known. This will lead to a lack of alignment	Need for additional modelling support to ensure the LHE understands the impact of any initiative over time on organisations. This has now been agreed	5	1	A	Jae Stringer	Agreement to proceed with whole economy model. EY working at pace on modelling work - starting at this date represents risk to delivering fully costed impacts on all organisations by 20th June	James Scaffield	20/05/2014	FDs agreed that they need a whole system model and that the EY model would be used to support this. Work has begun to populate the model. Starting at this date represents risk to delivering fully costed impacts on all organisations by 20th June
LLR4	Open	There is a risk that if the LHE does not agree a collective model of care then required changes in an acute and community setting will not be delivered as capacity will not be available in alternate settings	Stakeholder discussions and review of plans have revealed a lack of agreed future model of care for LHE to deliver aligned and sustainable plans in June 2014	5	3	R	Jae Stringer	Clinical Reference Group established. In hospital view on necessary model of care being led by Directors of Strategy at UHL and LPT	Geoff Raubenheim John Farenden/Tim Keenan James Scaffield	20/05/2014	A full day working session took place 07/05/2014 where EY facilitated small working groups to develop the model of care for each workstream. The work will feed into the Clinical Reference Group meeting 15/05/2014. LPT and UHL held a joint session 13/05/2014 to discuss their alignment
LLR5	Open	There is a risk that commissioner and provider I&E plans do not reconcile leading to a lack of whole system financial alignment	Review of existing plans shows that Commissioner and Provider financial plans are not aligned. This could impact ability of LHE to deliver aligned and sustainable plans in June 2014	5	4	R	Pete Shanahan	FDs working to align assumptions. Action plan agreed.	Pete Shanahan	14/05/2014	Update on alignment discussed 23/04. FDs agreed to work to align assumptions built into their models over the next two weeks. As at 07/05/2014 assumptions were not agreed. EY will follow up with FDs to get an update on how this work is progressing 14/05/2014.
LLR6	Open	There is a risk that the development of the 5 year strategy for the 20th June will not have the necessary clinical leadership across the LHE leading to poor buy-in to change	The development of the strategy is happening at pace with managerial leads driving the process, this therefore runs the risk of limited clinical buy-in	4	2	A	Jae Stringer	The Clinical Reference Group is now formed, and developing an agreed care for change. A health summit is re-scheduled for the 3rd June to seek clinical engagement	James Scaffield	03/06/2014	Clinical Reference Group meeting 15/07/2014 to review preparation for model of care
LLR7	Open	There is a risk that the system does not have strong leadership leading to poor acceptance and implementation of the strategy	As single point of system leadership is not above moment, with momentum being pushed by the programme								
LLR8	Open	There is a risk that the PMO is not resourced sufficiently to deliver the implementation plan for the strategy leading to poor delivery	PMO is forming, being driven by a high number of leads, concern is that the resources and tools the Programme will not be there from July 20								

Risk category	WS No.	Workstream	Ref	Status	Date Identified	Risk/Issue *There is a risk/issue that...*	Impact	Risk/Issue Assessment: Probability (1-5)	Risk/Issue Assessment: Impact (1 - 5)	Risk/Issue Assessment: Factor	Mitigation	Owner	Assessment (Post Mitigation): Probability (1-5)	Assessment (Post Mitigation): Impact (1 - 5)	Assessment (Post Mitigation): Factor	Date Closed
Data	5	Health and social care integration		Open	12 Nov 13	Robust approach to modelling to clearly articulate the benefits of health and social care integration and the ITF		2	2	4	Bespoke models for initiatives with a savings range developed. This information needs to be adapted to feed into the ITF					13/12/2013
Interdependency	5	Health and social care integration		Open	12 Nov 13	Risk of overlap with other workstreams		2	3	6	Workshop in January (date TBC) to discussion out of hospital workstreams and map dependencies					
Resourcing	5	Health and social care integration		Closed	12 Nov 13	Client resource may not be available to test high level operational model as it develops		3	5	15	Project Board to free up time for resources to input	JS			0	13/12/2013
Resourcing	5	Health and social care integration		Closed	12 Nov 13	Workstream will require client resource to support collection of data to establish service baseline and input into phase 1 financial model for Healthier Northamptonshire		3	4	12	RA to ensure access to client resource and information					13/12/2013
Scope	5	Health and social care integration		Closed	12 Nov 13	The ITF requirements change the focus of the workstream and its deliverability by December		2	4	8	Meeting with AJ and PM to understand the ITF requirements and how the workstream can act as an enabler					13/12/2013
Transition	5	Health and social care integration		Open	10 Dec 13	Insufficient resource (capability and capacity) to move forward with the 90 day plan - developing a full business case and service specification, as outlined in the proposed implementation plan		5	5	25	Review current resourcing and redirect appropriate resource to the workstream (NCC, None, Corby)					
Engagement	5	Health and social care integration		Closed	10 Dec 13	Workstream will require client resource to review deliverable and provide feedback		3	3	9	Project Board to free up time for resources to input					13/12/2013

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