**Updated July 2014**

# Better Care Fund planning template – Part 1

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

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

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

## 1) PLAN DETAILS

### a) Summary of Plan

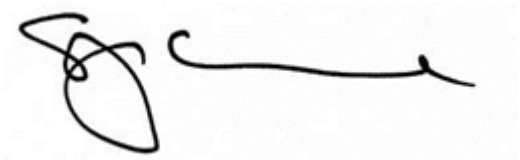
| | |
|---|---|
| Local Authority | **Leeds City Council** |
| | |
| Clinical Commissioning Groups | **NHS Leeds South and East CCG** |
| | **NHS Leeds West CCG** |
| | **NHS Leeds North CCG** |
| | |
| | |
| | |
| Boundary Differences | **None. 3 x CCGs are jointly coterminous with local authority**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

## b) Authorisation and signoff

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

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

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

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

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

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

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

# 2) VISION FOR HEALTH AND CARE SERVICES

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

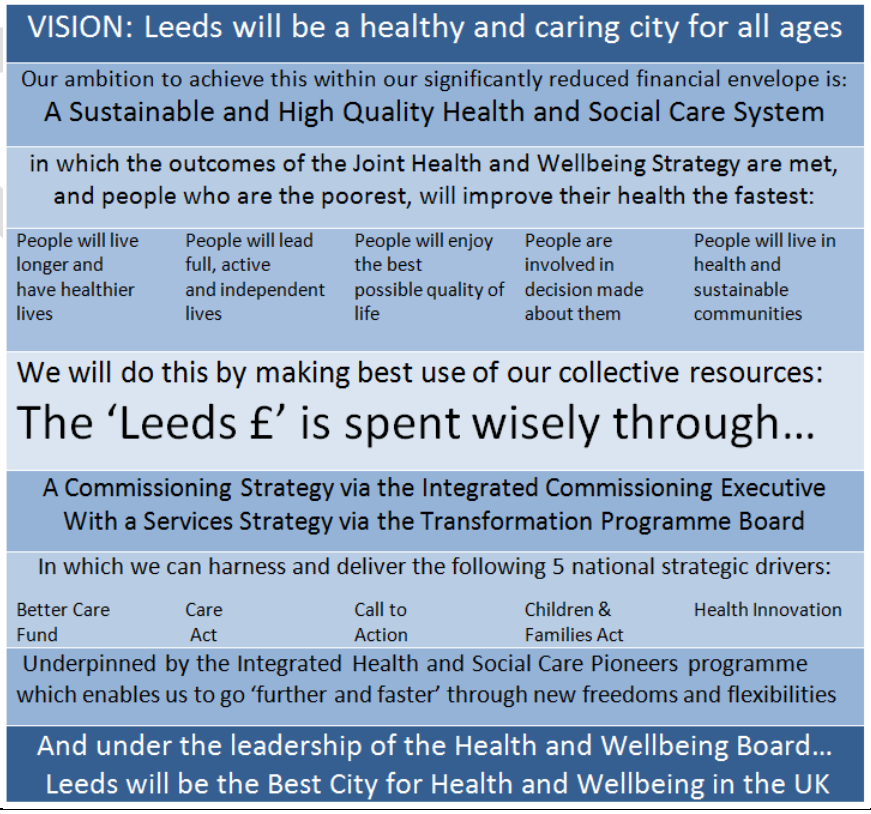
**Introduction**

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

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

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

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



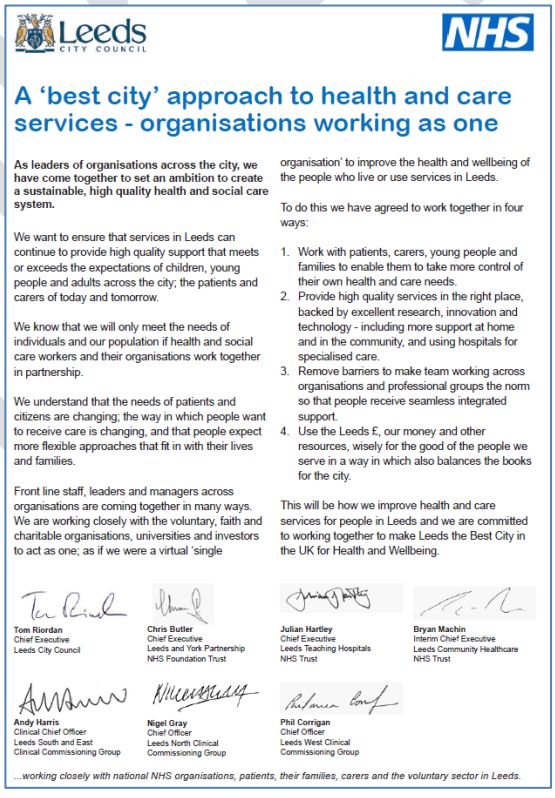
**Vision for integrated health and care services**

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

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

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

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



Leeds CITY COUNCIL

NHS

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

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

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

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

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

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

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

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

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

**Tom Riordan**
Chief Executive
Leeds City Council

**Chris Butler**
Chief Executive
Leeds and York Partnership NHS Foundation Trust

**Julian Hartley**
Chief Executive
Leeds Teaching Hospitals NHS Trust

**Bryan Machin**
Interim Chief Executive
Leeds Community Healthcare NHS Trust

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

**Nigel Gray**
Chief Officer
Leeds North Clinical Commissioning Group

**Phil Corrigan**
Chief Officer
Leeds West Clinical Commissioning Group

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

Agreement for a high-quality health and social care system

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

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

South Leeds Independence Centre (SLIC)

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

Artist impression of what the completed ALL will look like

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

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

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

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

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

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

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

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

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

**JSNA**

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

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

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

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

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

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

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

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

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

**The Joint Health and Wellbeing Strategy**

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

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

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

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

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

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

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

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

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

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

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

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

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

Our outcomes framework

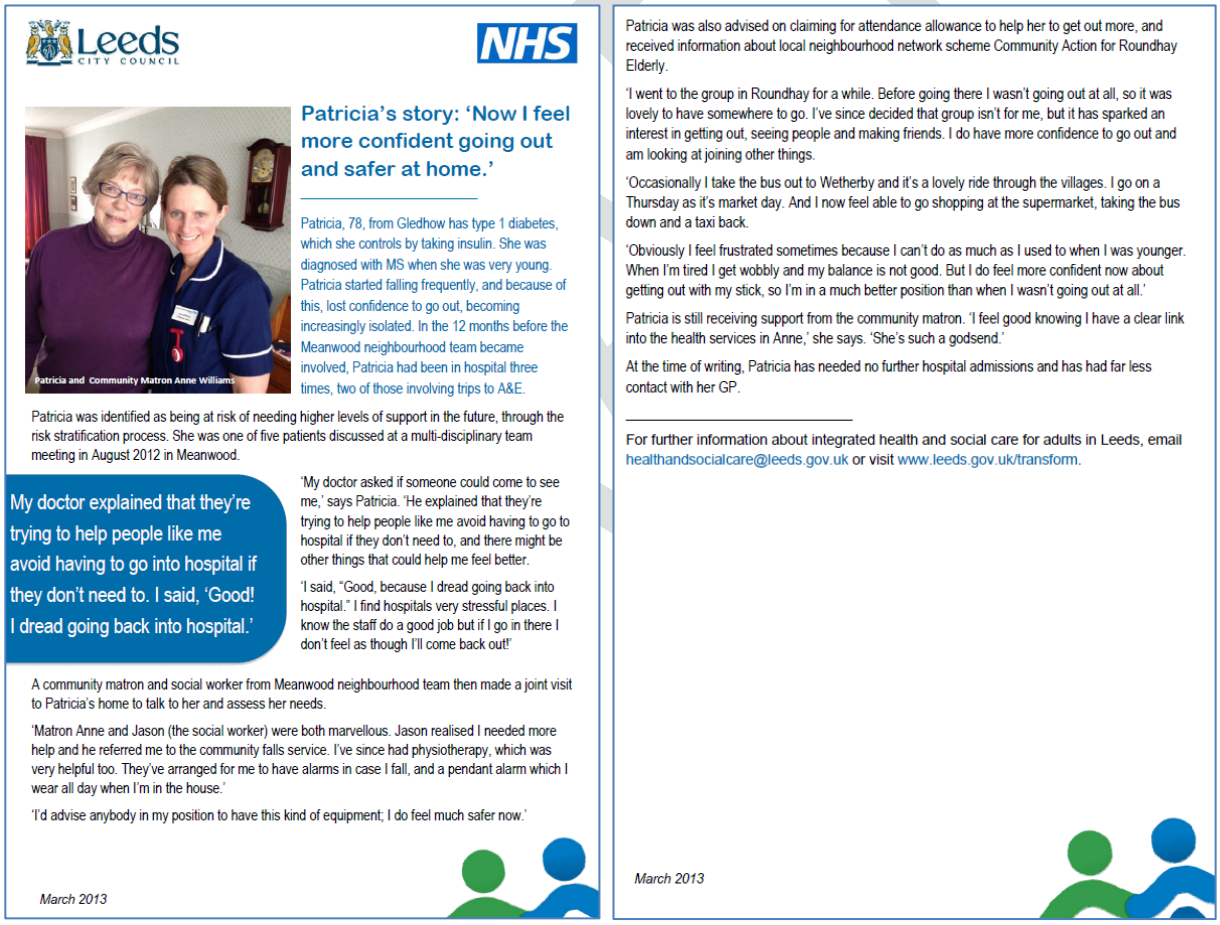
Described in section 8 of this narrative submission is the input and engagement of service users and the public. In line with findings from the HealthWatch consultation we undertook (see appendix 4 for a report on the consultation), it is clear the three objectives of the BCF (Reducing the need for people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

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

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

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

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



Leeds CITY COUNCIL

NHS

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

Patricia and Community Matron Anne Williams

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

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

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

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

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

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

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

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

*March 2013*

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

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

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

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

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

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

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

*March 2013*

Patricia's story

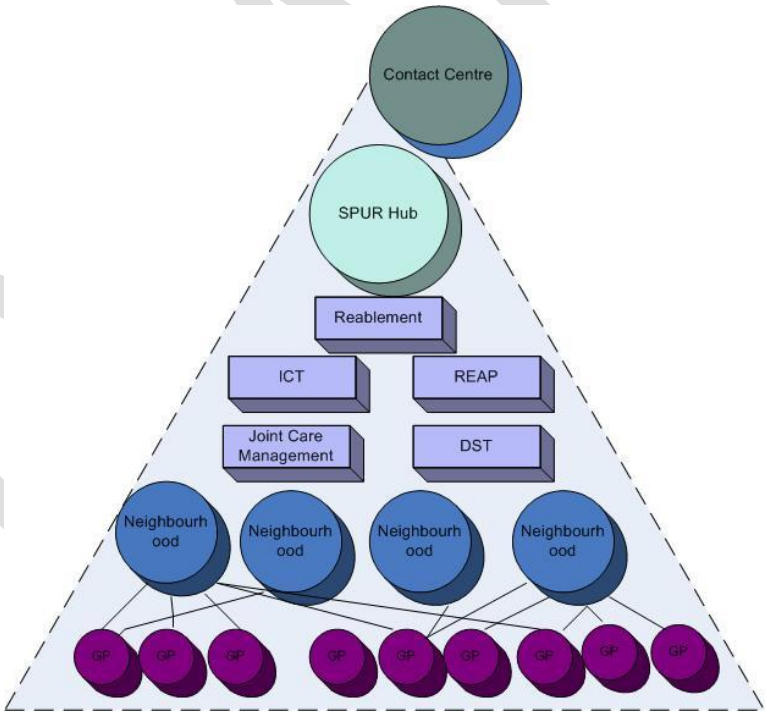
Our BCF is geared towards contributing to a high quality and sustainable health and social care system, through the broader Transformation Programme. In particular, the schemes will support the work programme "Effective admission and discharge" - Integrated management of patients to reduce dependence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

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

**Care and support**

*Where we were…*

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

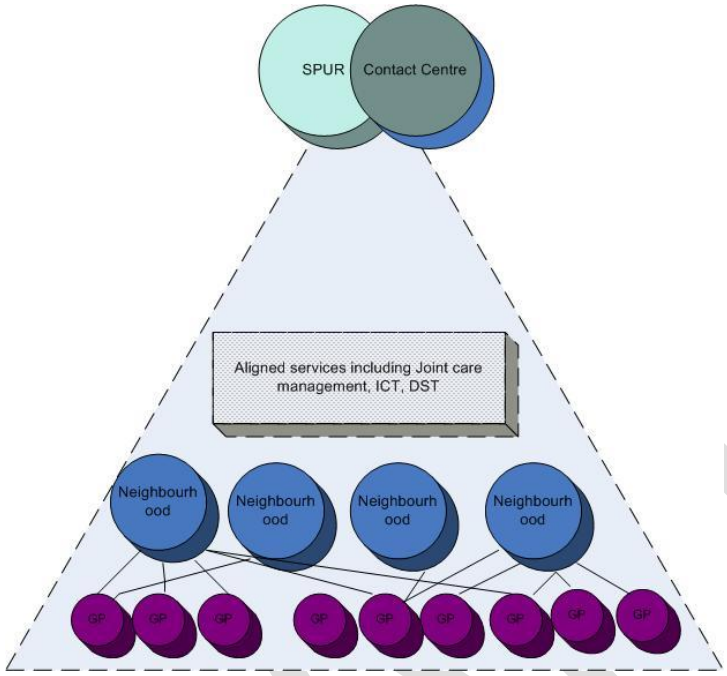



Where we were

*Where we are now…*

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

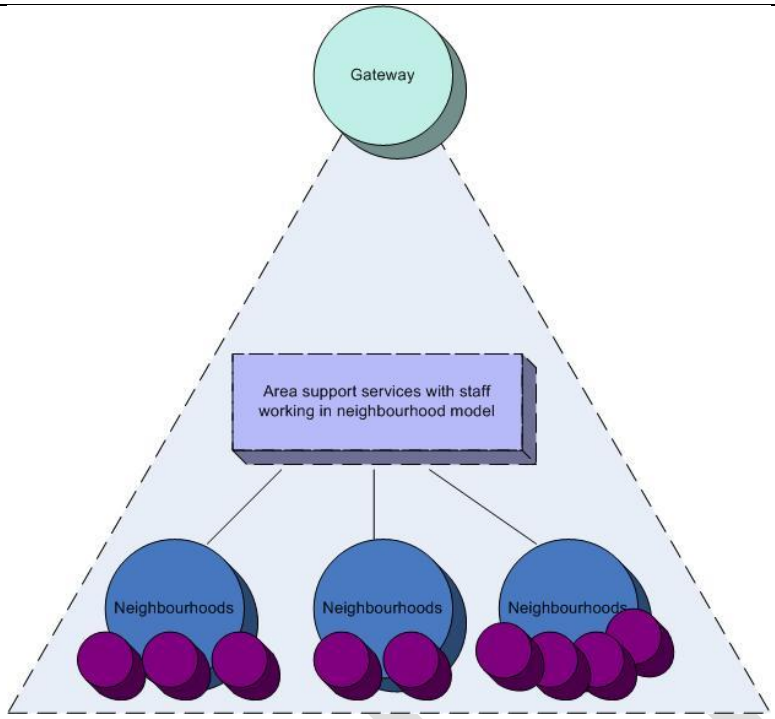
- Much more involvement from ‘wraparound’ services.
- Projects such as the including South East Initiative have supported the development of a model - avoiding a phased rollout but mitigating risk of a ‘big bang’.




Where we are now

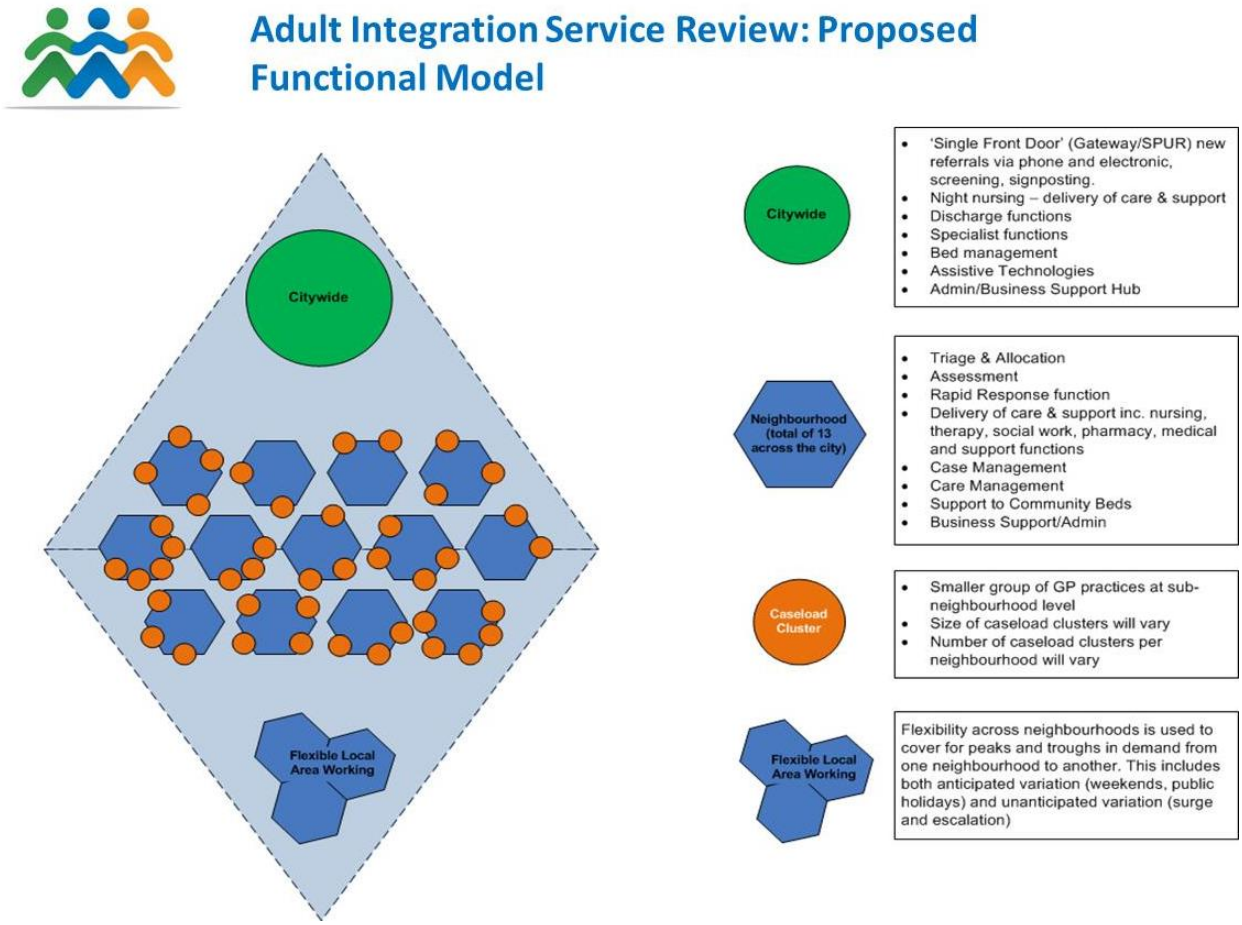
*Where we plan to be…*

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




Where we plan to be

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

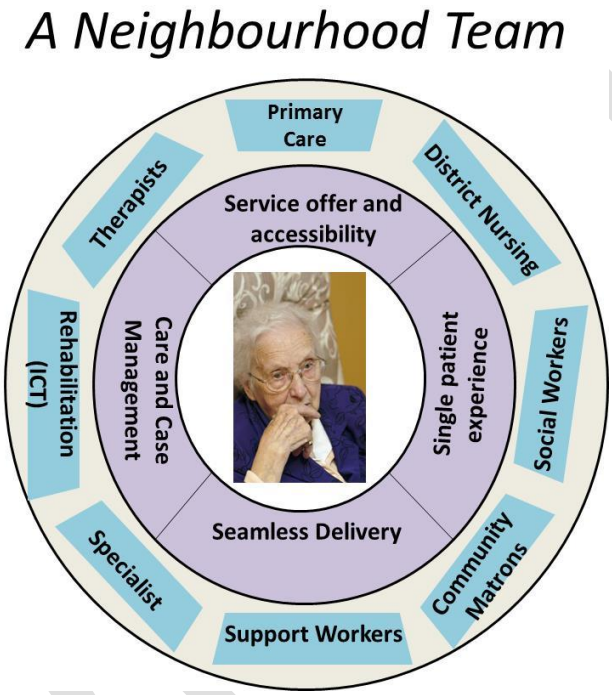



Proposed functional model for care and support

*What will this mean for service users…*

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

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




Proposed components of the Neighbourhood Team and the service user experience

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

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

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

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

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

**The Leeds approach to developing our BCF**

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

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


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

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

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

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

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

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

**Aims**

As an Integration Pioneer, we will be aiming:

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

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

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

**Objectives**

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

Our BCF objectives are:

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

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

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

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

## What we will measure

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

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

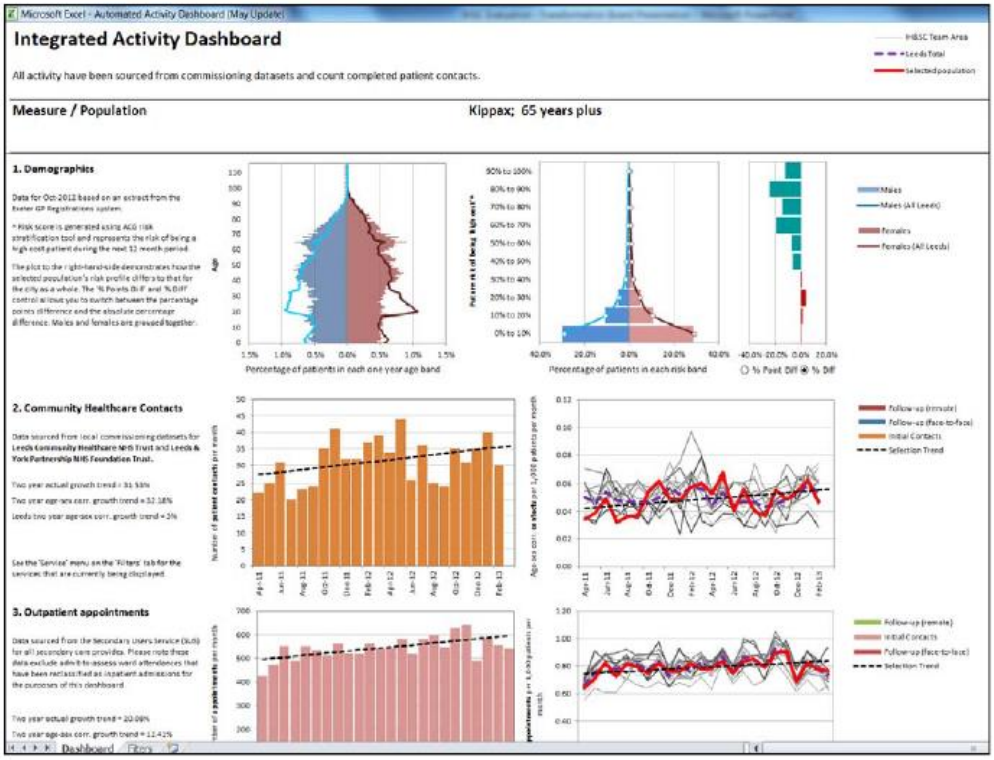
- Our indicator will focus on the total number of bed days spent in care/residential home facilities. In Leeds, we believe that our success in supporting more people to live longer in their own homes is evidenced not by the rate of admissions to residential care, but by the combination of those admitted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

the whole health and social care system.

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

**How we will measure**

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




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

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

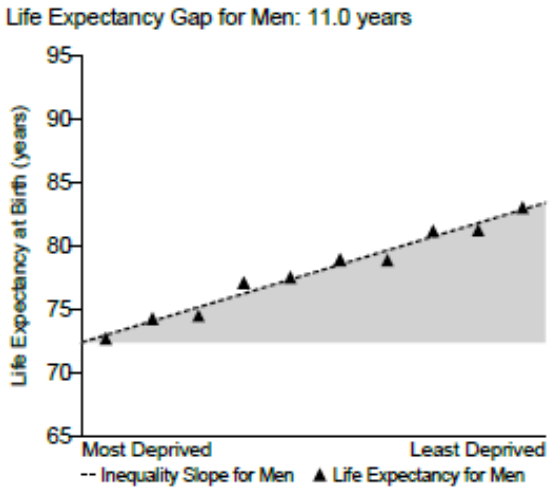
Achieving the objectives set out above will enable us to fully realise the potential from our Pioneer status, both in terms of transforming services for better outcomes for the people of Leeds and sharing our learning across the country.

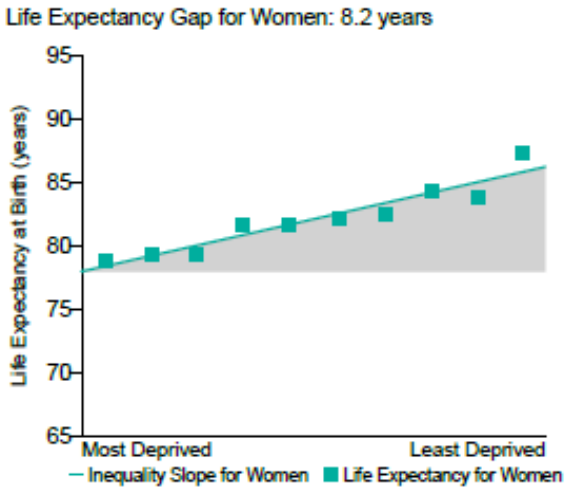
# 3) CASE FOR CHANGE

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

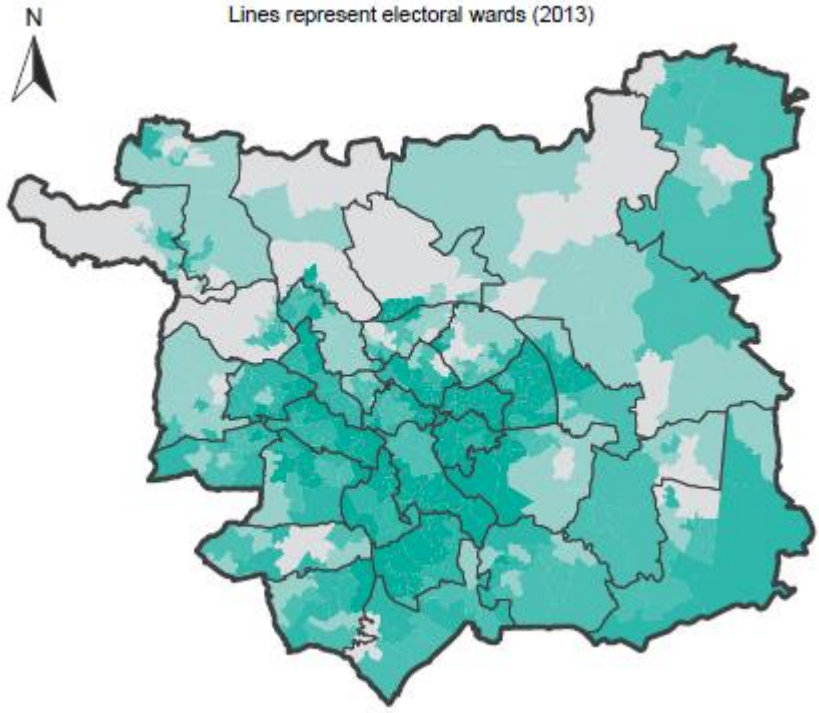
As described in our JSNA, Leeds is a diversity city comprising of multiple communities each with their own specific health and social care needs. We know significant health inequalities persist in Leeds between the most affluent communities that are typically on the outer fringes of the city, and the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

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




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




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

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

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

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

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

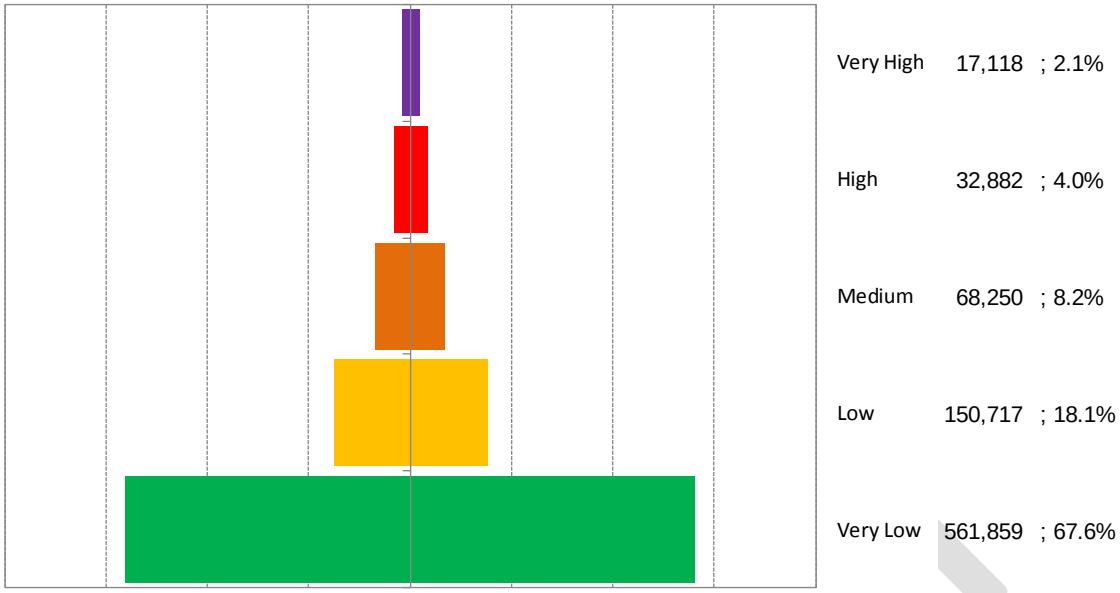
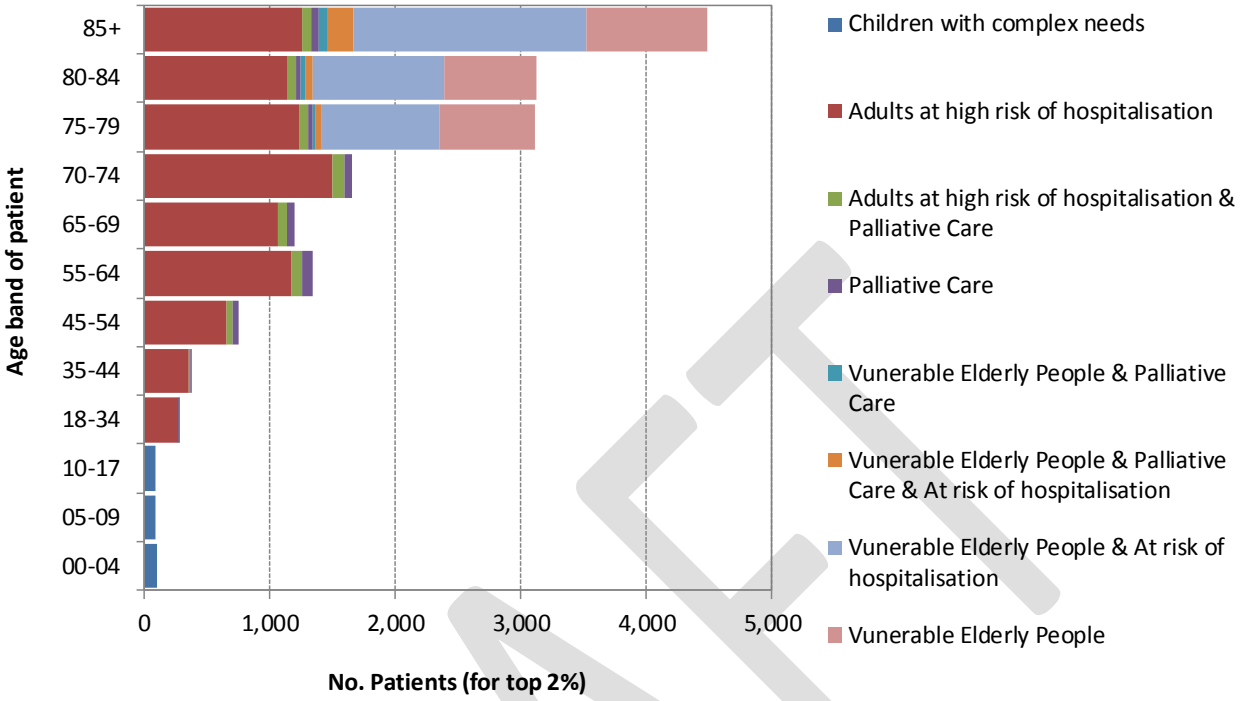



Figure 1 above illustrates the risk profile for Leeds split by risk bands. Just over 2% of the city's population is flagged as of being 'very high' risk, as defined as individuals who are predicted to use 6.8 times or more healthcare resource in the next 12 months compared to the average person. We know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

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

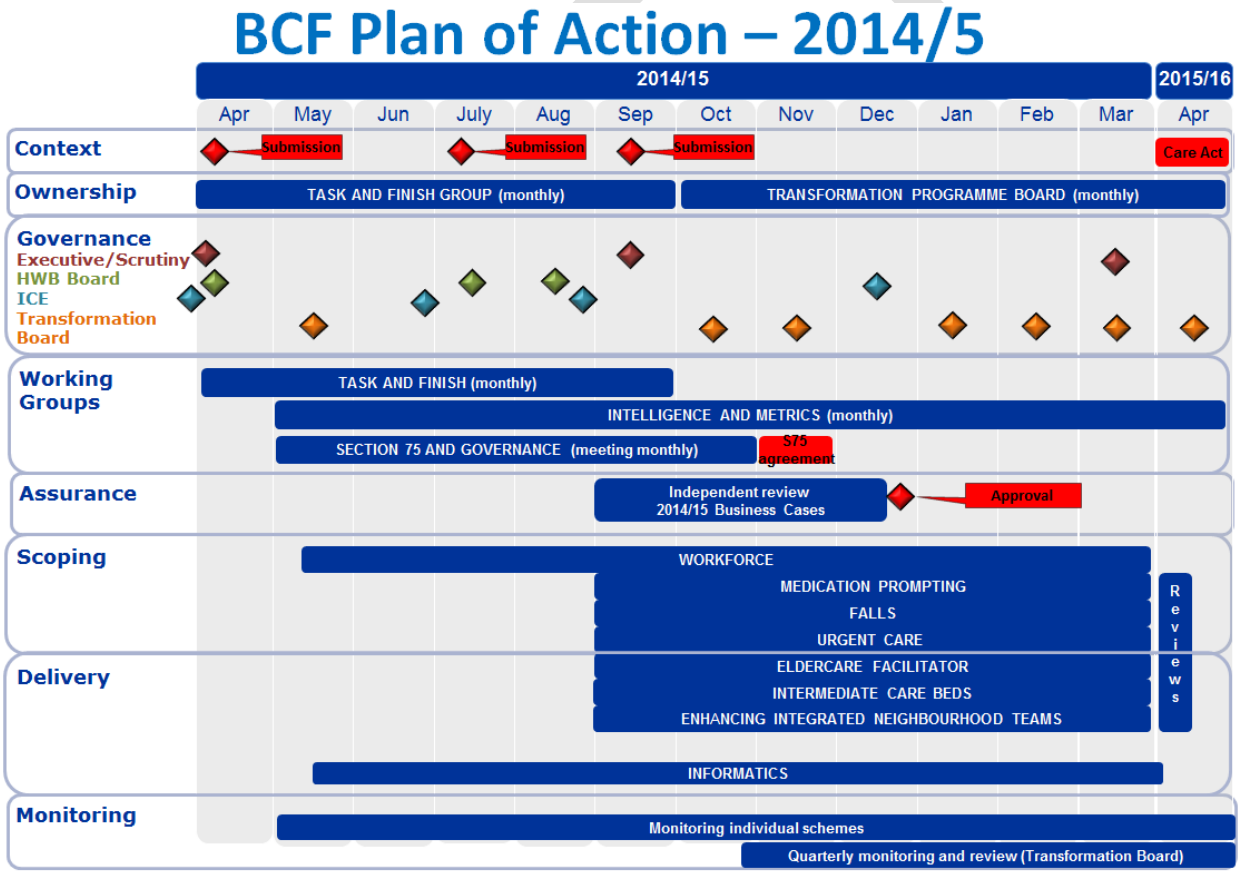



From the intelligence the city has collated we recognise that not all 'at risk' patients are actively being managed and we also know that for certain services that case manage complex patients, not all patients on the service's caseload are flagged as being high risk patients. This suggests that opportunities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

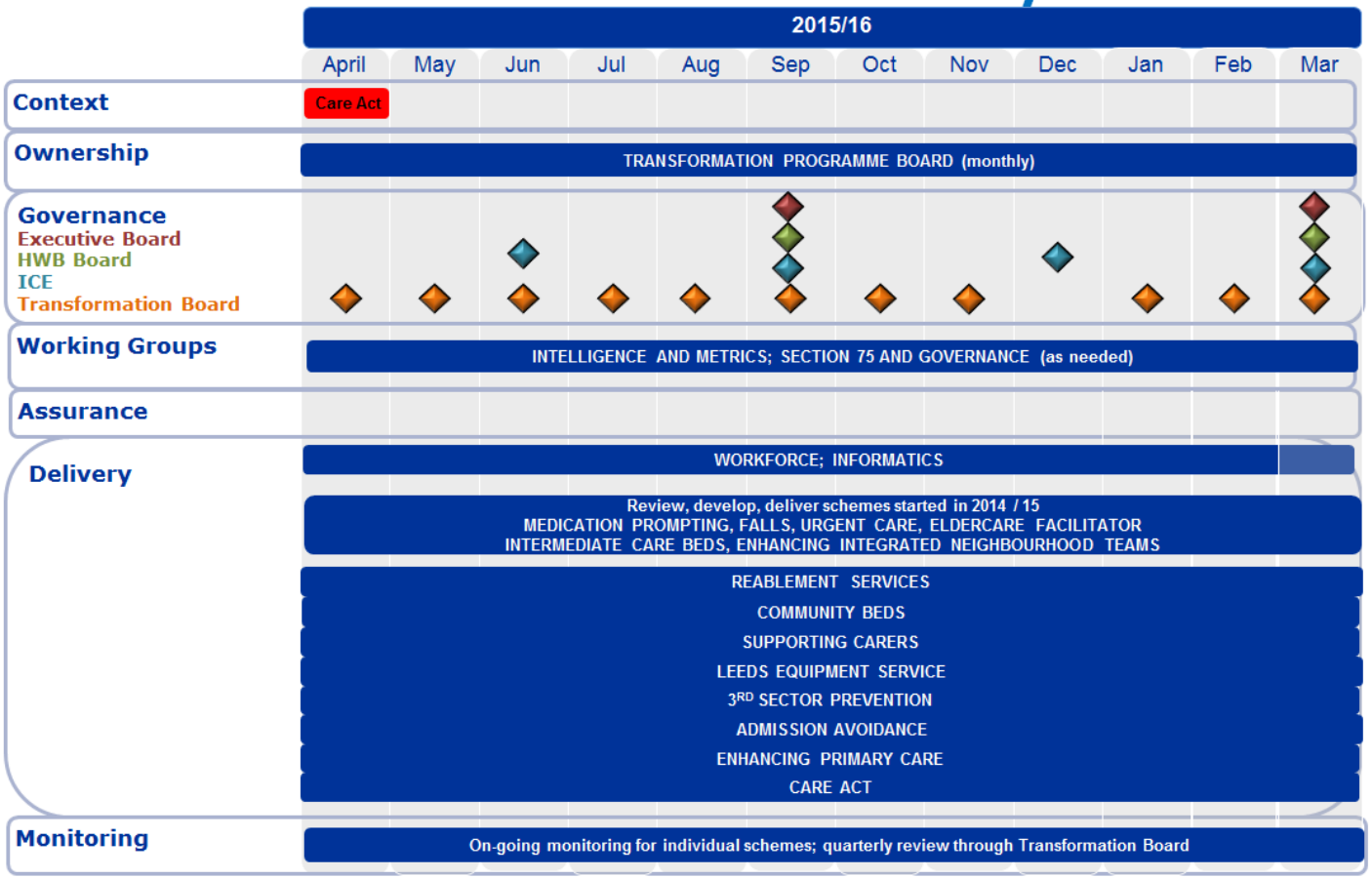
# 4) PLAN OF ACTION

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

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



# BCF Plan of Action – 2015/6



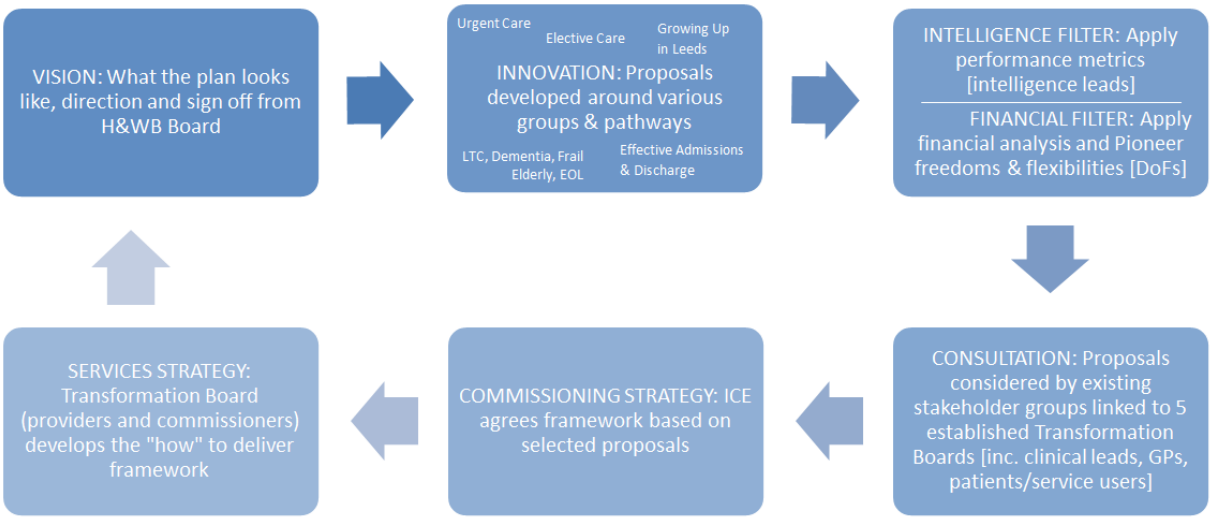
b) Please articulate the overarching governance arrangements for integrated care locally

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

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

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

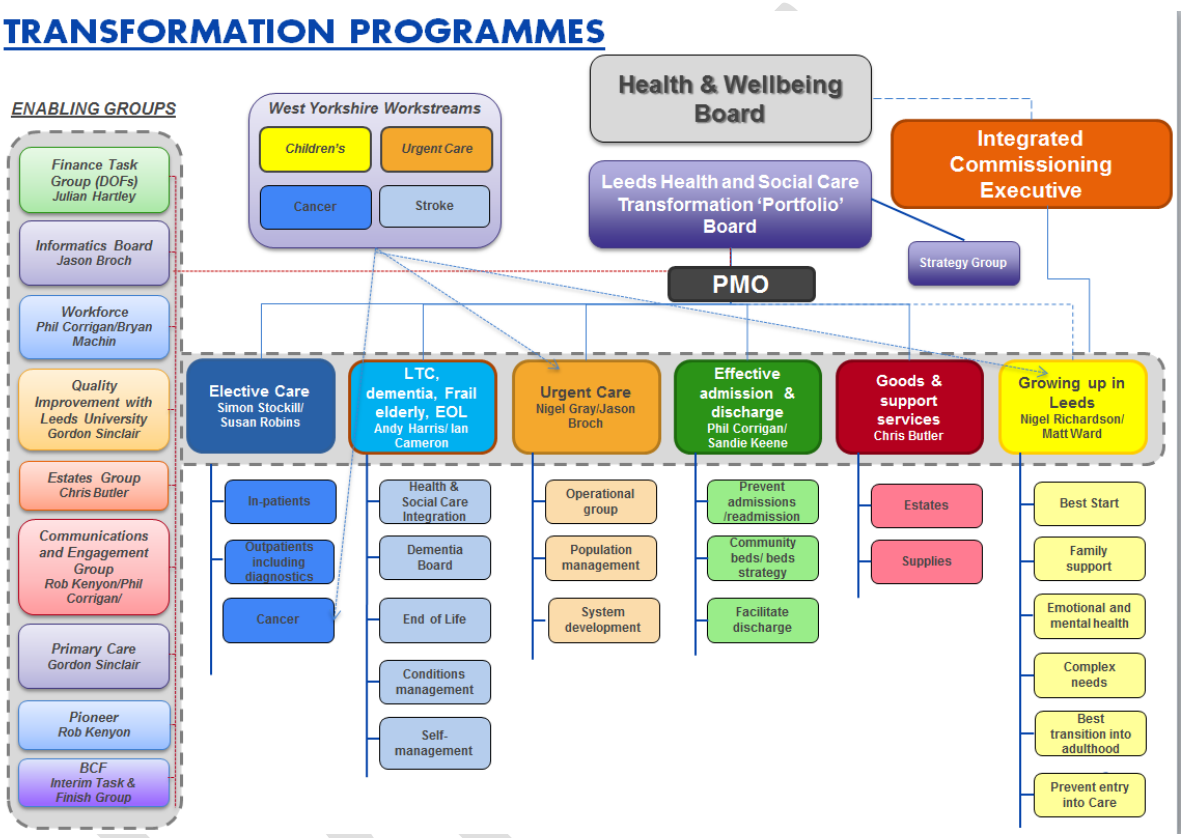
The following is the agreed process for developing all Transformational Changes in the city.




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

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

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




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

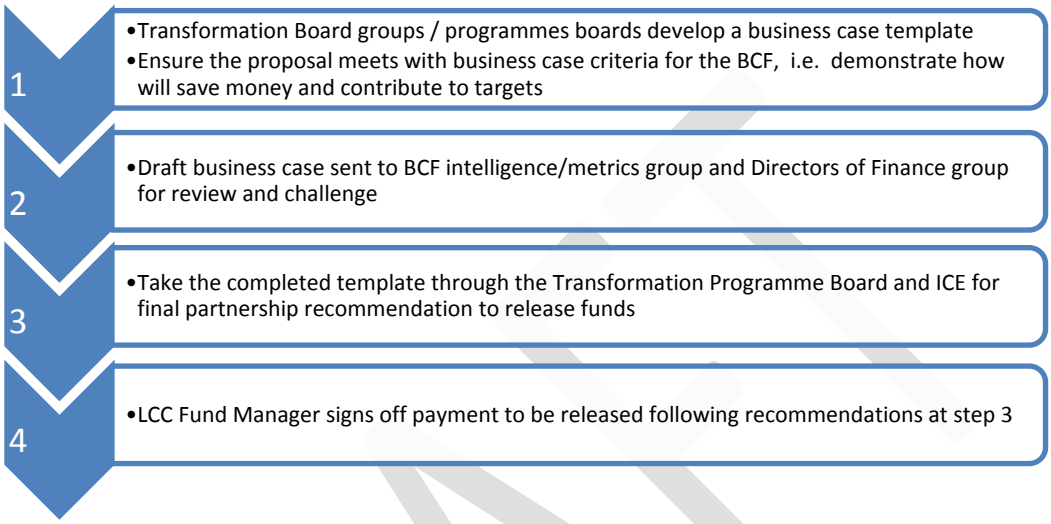
Two additional groups specifically to manage the BCF have also been established.

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

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

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

The following describes the business case approval process.




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

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

d) **List of planned BCF schemes**

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

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

# 5) RISKS AND CONTINGENCY

## a) Risk log

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

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

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

**b) Contingency plan and risk sharing**

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

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

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

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

The following general principles will apply:

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

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

# 6) ALIGNMENT

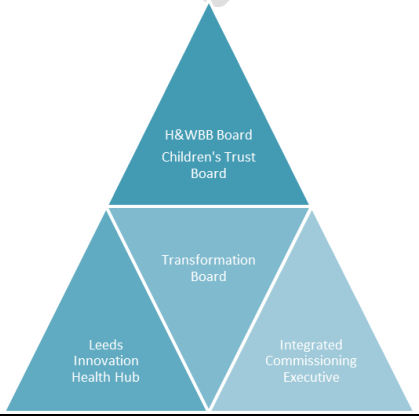
a) Please describe how these plans align with other initiatives related to care and support underway in your area

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

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

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

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




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

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

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

**Leeds' Transformation Programme and 5 Year Strategy**

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

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

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

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

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

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

three key objectives i.e.:

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

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

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

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

**Local Authority 2 Year Operating Plans**

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

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

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

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

# 7) NATIONAL CONDITIONS

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

**a) Protecting social care services**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

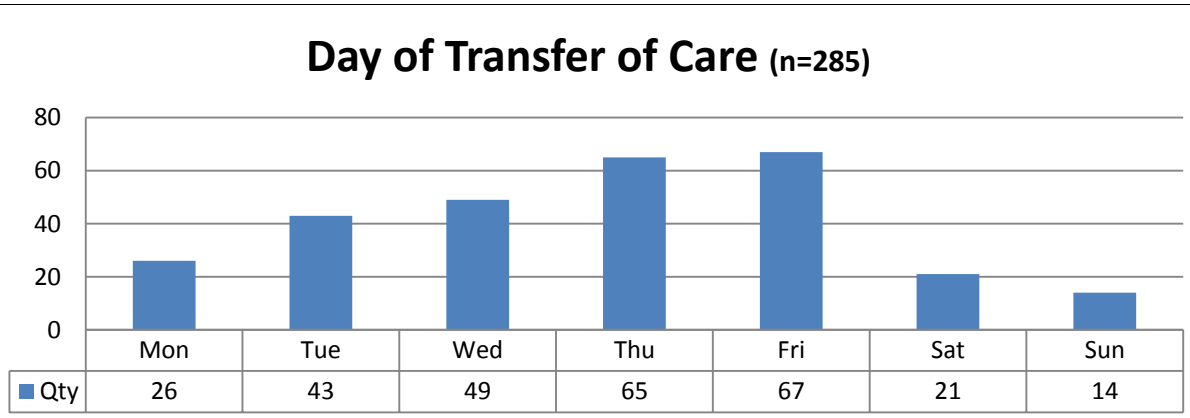
**b) 7 day services to support discharge**

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

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

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

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




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

**Action plan for 2014/15**

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

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

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

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

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

**Future plans**

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

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

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

**c) Data sharing**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# 8) ENGAGEMENT

### a) Patient, service user and public engagement

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

**BCF engagement**

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

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

**Ongoing engagement**

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

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

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

## Charter for Involvement in Integration

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

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

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

.....

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

Agreed by Integrated Adult Health and Social Care Board 30.5.12

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

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

**b) Service provider engagement**

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

i) NHS Foundation Trusts and NHS Trusts

**BCF engagement**

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

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

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

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

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

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

**Ongoing engagement**

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

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

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

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

ii) primary care providers

**As above**

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Citizen engagement

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

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

**c) Implications for acute providers**

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

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

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

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

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

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

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

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

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

# ANNEX 1 – Detailed Scheme Description

Please see attached scheme business cases/descriptions.

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

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

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

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

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

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

# ANNEX 2 – Provider commentary

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

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

**For HWB to populate:**

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

**For Provider to populate:**

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