NHS
Leeds South and East
Clinical Commissioning Group

NHS
Leeds West
Clinical Commissioning Group

Leeds CITY COUNCIL

NHS
Leeds North
Clinical Commissioning Group

# LEEDS BETTER CARE FUND

# NARRATIVE PLAN FOR 2016-17

**3rd May 2016 - DRAFT**

INSPIRING CHANGE
making Leeds the best city for health and wellbeing

## Contents



## Submission Summary

| | |
|---|---|
| Local Authority | **Leeds City Council** |
| Clinical Commissioning Groups | **NHS Leeds South and East CCG** |
| | **NHS Leeds West CCG** |
| | **NHS Leeds North CCG** |
| Date of Narrative Plan submission 1: | **March 21st 2016** |
| Date of BCF Planning return submission 1:<br>Date of BCF Planning return submission 2: | **March 2nd 2016**<br>**March 21st 2016** |
| Value of pump priming 2014/15 | **£7.759m** |
| Value of pooled budget 2015/16 | **£54.9m** |
| Value of pooled budget 2016/17 | **£55.9m** |
| National conditions | **Most plans are in place, the outstanding plan for Non Elective Admissions is reliant on completing the current contract negotiation round with the Acute Trust.** |

## Authorisation and sign off

| | |
|---|---|
| **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** | 22.4.16 |

| | |
|---|---|
| **Signed on behalf of the Clinical Commissioning Groups** | Leeds South and East CCG |
| **By** | Matt Ward |
| **Position** | Chief Operating Officer |
| **Date** | 22.4.16 |

| | |
|---|---|
| **Signed on behalf of the Council** | Leeds City Council |
| **By:** | Steve Hume |
| **Position** | Chief Officer Resources and Strategy |
| **Date** | 22.4.16 |

# 1. INTRODUCTION

Leeds has used the BCF to take forward its stated vision for health and social care described in its BCF national submission 2015/16. The vision remains the main guiding force behind the collective work that has taken place this year. The extension of BCF has given us the opportunity take stock of distance travelled, review schemes and acknowledge the valuable contribution made by the BCF in advancing health and social care ambitions in Leeds.

A period of one year is not a long time to see the full impact of scheme contribution to the system. Not all schemes have had the time to come to full fruition, but where an 'invest to save' scheme is beginning to show a positive impact on the system there is commitment to securing on going funding. Where schemes have not received BCF funding for 2016/17 they have been considered under the CCGs planning process so that those schemes aligned to CCG operational plans and the Sustainability and Transformation Plan (STP) could be funded (from outside of the BCF) and moved into mainstream contract arrangements. Some schemes that have not delivered their expected benefits have also not been taken beyond pilot phase.

The Leeds Narrative Plan outlines the local BCF journey and key issues and deliverables going forward. The advent of the STP gives us the opportunity to place the BCF within an overarching longer term strategy that maybe better able to deliver the vision that we set out with in 2015/16. The aim of the Leeds STP is to build on the work of integration that has been undertaken and supported by the BCF, but with a wider and more progressive reach. The goal is to create healthy living services, high quality and safe integrated services in primary care and the community and improve system flow. Whilst the BCF brought together existing funding from health and social care it did not bring any new monies in to deal with the challenges the BCF looks to address. Leeds was in a fortunate position in that it did set aside existing funds to invest in joint services. The aims associated with the BCF are significant and going forward the reality is that the STP will be challenged to encompass the major aims of BCF, System Resilience and System Flow. BCF does not operate in isolation from other initiatives in the city.

# 2. VISION FOR HEALTH AND CARE SERVICES

## 2.1 Vision

The health and social care community in Leeds has worked 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 helping to deliver the 5 year strategy for health and social care, articulated further in our Sustainability and Transformation Plan.

The Leeds vision for integrated health and social care is based on what local people have told us, as to what 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.

Our outcomes framework below sets out our aims for the delivery of the BCF schemes as well as wider strategic programmes like the STP.

**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. |

## 2.2 Objectives

The BCF sits within a wider programme of transformation which has seen progressive developments in integrated service delivery and joint commissioning. The aim of the Transformation Board has been to achieve the following:

- 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

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

objectives also contribute to the delivery of key themes within the Joint Health and Wellbeing Strategy.

- 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

## 3. THE BCF JOURNEY 2015/16

In 2015/16 the BCF has been used to further our ambitions for transforming services in line with national requirements and local goals. The schemes funded by BCF were chosen to respond to the three key themes which cover the aims and objectives of BCF and the wider transformation programme. Pre-existing services/projects as well as new 'invest to save schemes' were identified and brought together under the BCF programme.

The performance of the BCF during FY15/16 has been assessed against the following high-level objectives.

*Objective 1: Reducing the need for people to go into hospital or residential care*

BCF has funded a number of initiatives and services that collectively support people to live independently in their own communities, and are anticipated to reduce individual's need for hospital-based care including:

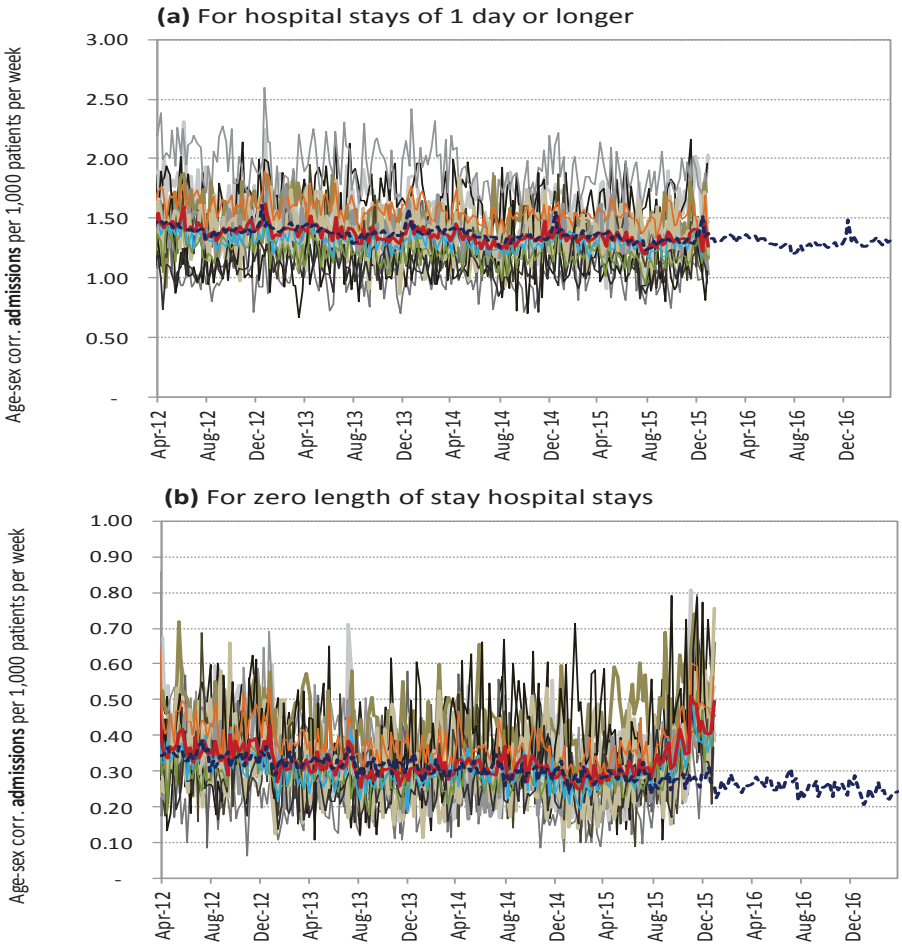
- Reablement services
- Supporting Carers
- Leeds Equipment Service
- 3rd sector early intervention
- Community matrons
- Social care to benefit health
- Disabilities facilities grants
- Enhancing primary care
- Eldercare Facilitator
- Medication prompting - Dementia
- Falls prevention
- Enhancing Integrated Neighbourhood Teams
- Urgent Care Services
- Care Act Implementation

Emergency admissions to hospital provide a proxy measure for the impact of these schemes on achieving the stated objected of reducing the need for hospital-based care. Whilst Leeds has not achieved its ambition of reducing all emergency

admissions by 3.5% during 2015, this headline masks some notable improvements, particularly in relation to reducing the numbers of patients who stay in hospital one or more night following an emergency admission (where admissions have seen a significant reduction of 0.03 admissions per 1,000 patients per week over the first three quarters of FY15/16 – see Figure 1). Furthermore, Leeds has seen a reduction in the numbers of people accessing A&E services (down by 0.17 attendances per 1,000 population per week). These reductions are consistent with improvements in how the wider system is delivering out of hospital care.

Figure 1 is the weekly age-sex standard rates for emergency admissions to hospital for Leeds-registered patients; (a) Includes all hospital stays where the patient stayed beyond mid-night whilst (b) captures patients who were discharged on the same day as their admission. The red line represents the Leeds average, and the dotted purple line represents the seasonally adjusted linear trend based on the period 1st April 2009 to the 31st March 2015. The green, blue and orange lines represent the Leeds North, Leeds West and Leeds South & East CCG totals, whilst the grey lines represent the 13 Integrated Health & Social Care Neighbourhood Team areas. The age-sex standardisation approach used corrects for demographic changes – hence the underlying trend is indicative of the changes in service uptake.

**Figure 1**



Despite these positive indicators, the reality facing Leeds is that short-stay admissions to hospital significantly increased during the autumn of 2015. Figure 1 (b) shows an increase that can be explained by a re-configuration of services within Leeds Teaching Hospitals NHS Trust that increased the bed base available for short-stay admissions. The challenge for FY16/17 will be to work with Leeds Teaching Hospitals to ensure short-stay capacity is used appropriately for the benefits of patients, and to identify opportunities for using out-of-hospital services as alternatives to short-stay admissions.

Care home admissions data also provides some indication of the impact of the investment that has been made through the BCF. Whilst permanent care home admissions for people over the age of 65 are estimated to be higher than last year, the number of overall bed weeks is considerably lower than previous years. Therefore, whilst more people may be entering a care home placement they are doing so for a shorter time and are therefore being supported to be independent at home for longer. (See Planning Template for details)

*Objective 2: Helping people to leave hospital quickly*

The following schemes contribute to objective 2:

- Community beds
- Supporting Carers
- Leeds Equipment Service
- 3rd sector early intervention
- Community matrons
- Social care to benefit health
- Disabilities facilities grants
- Expand community Intermediate Care beds
- Enhancing Integrated Neighbourhood Teams

In line with BCF guidance, the Delayed Transfer of Care (DTOC) metric has been used as an indication of whether the plan for 2015/16 has delivered on this objective. Whilst bed days lost associated with DTOC increased during Q1 and Q2 of FY15/16, this deteriorating position can largely be attributed to improvements in the identification of patients who met the DTOC definition. This is consistent with total occupied bed day data, which demonstrates bed occupancy for emergency admissions to hospital has been remarkably stable for the last six years.

Following a deep dive review into discharge functions between commissions and providers in October 2015, an improvement plan was agreed and since this time significant reductions in DTOCs have been achieved. With steer from the city's System Resilience Group, work continues to streamline the discharge process and to ensure out-of-hospital services has adequate capacity to manage discharges in a

timely way. This will continue to be a priority for the BCF moving into FY16/17. (See DTOC trajectory in the Planning Template for details)

*Objective 3: Supporting people to remain out of hospital or residential care following a stay in hospital*

The following schemes contribute to objective 3:

- Reablement services
- Supporting Carers
- Leeds Equipment Service
- 3rd sector early intervention
- Admission avoidance
- Community matrons
- Social care to benefit health
- Memory Support Workers
- Enhancing Integrated Neighbourhood Teams
- Care Act

Ensuring individuals who are admitted to hospital are managed appropriately on discharge to support them to live at home and avoid re-admission to hospital is central to many of the services that are funded via the BCF. Emergency admissions to hospital data indicates that for the last couple of years re-admissions have been approximately 11 patients per 1,000 population (for people who had 2 or more admissions in the previous 12 months). These represent the lowest rates for the past six years. Similarly, the numbers of people having two or more A&E attendances within a 28 day period has remained stable (at 1.8 patients per 1,000 population) for the past six years. Whilst these measures do not in themselves indicate what proportion of re-admissions might be avoided if out-of-hospital care were optimal, they provide assurance that efforts to discharge patients in a timely way has not negatively impacted re-admission or re-attendance rates.

Furthermore, the proportion of people who receive reablement services following discharge from hospital and are still at home after 91 days post-discharge increased to 92% (based on Q1 & Q2 FY15/16 provisional data). This represents an improvement on last year's comparator and national average, and is deemed a good level of performance for the city. (See Reablement trajectory in the Planning Template for details)

In summary, putting aside the increase in short-stay admissions to hospital that can be attributed to structural changes within the hospital system, the performance of the health and social care system in Leeds for FY15/16 has broadly shown gradual to steady improvements in terms of the high-level objectives set out above. Looking towards FY16/17 we now have the opportunity to consolidate and expand upon what works well and to explore through the West Yorkshire Urgent Care Vanguard and the

Sustainability & Transformation Plan areas where the BCF can complement wider system changes to deliver benefits for Leeds.

## 4. The BCF GOING FORWARD - 2016/17

The BCF has helped sustain levels of service delivery during challenging times where the system has seen an increase in people with complex health needs accessing the NHS. This has driven cost up in non - elective admissions (NEA) which has meant we have not been able to meet our target on NEAs. However, because we have had a BCF programme in place it has helped to strengthen our out of hospital care sector which seems to have had a positive impact on other indicators relating to hospital admission as shown in section 3. We have also sustained and improved implementing new ways of working across services that has had a positive impact on peoples live.

Going forward the BCF will be used to maintain these services and demonstrate their value to the delivery of the STP. We will also be seeking to mainstream those services that were badged as 'invest to save' where there is evidence that they are having a positive impact on our transformation goals.

As described in section 2.1 and 2.2 when we set out to deliver change using the BCF as an enabler, we set up governance arrangements (see section 7) that clarified how BCF schemes would report progress. Providers were consulted and were involved in the way BCF was delivered; they were notified of expectations in relation to the aims of the BCF and consequences of not meeting these aims. In accordance with these procedures actions have been followed through as plans for 2016/17 were finalised.

### 4.1 Issues that the BCF will address in 2016/17

BCF schemes will continue to address the key issues facing Leeds described in the original submission. The following is a summary.

*Targeted support for those at risk:*
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 from community interventions such as the Proactive Case Management service. In addition caseloads are being re-prioritised 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. We anticipate that this will contribute to a reduction in NEAs in line with the trajectory outlined in the Planning Template (see Section 5.1).

*Providing a seamless quality experience of care for people:*
The quality of service experience and ease of access was said to be important when service users and carers were consulted during the creation of the first BCF plan. Therefore we have set up "wrap around" community services (community health and social care services) providing coordinated support 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. We will continue to complete this work particularly with the establishment of a shared front door for referrals in 2016/17. By doing so we anticipate that patients' positive experience of integrated care will be sustained (as monitored via the local patient experience measures – see Planning Template Section 5.6).

*Supporting carers:*
Information from Carers has been used to invest in what they say they need. 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. To achieve this BCF has allocated £2 million which will continue to fund carers' breaks, support to those caring for people with dementia and those who have recently been bereaved. This funding will help avoid cases of 'carer' breakdown, with the associated positive impact upon emergency admissions to hospital.

*Completing the work on integrating health and care:*

Many of the schemes funded by BCF are geared towards this BCF goal of moving service and care provision into a seamless process that the service user/patient and their carer can access easily and use with ease when in need. The following schemes are particularly important in completing this work:

Integrated Neighbourhood Teams (INTs) – these comprise community health services and adult social care staff. The teams are aligned to, and work closely with, General Practices. The practice list and predictive risk capability has allowed a joint focus on those people at high or increasing risk of a hospital admission, and to work proactively with people living with long-term conditions to manage their health better. The next stage will be building closer integration with clinicians from the acute hospital and mental health Trusts and fostering local leadership and team development.

Out of hospital services – these comprise a range of local authority, 3rd sector and private sector services. They have been funded by BCF to extend the provision of service in the community to prevent hospital admission and speed up discharge from hospital. They will continue to be sustained in 2016/17 either as part of BCF or as a mainstreamed service. They will work closer together to ensure that the right care is being provided at the right time in a seamless way.

Further integration of commissioning – Leeds has a good track record of joint commissioning across the Local Authority and Clinical Commissioning Groups which will be taken further in 2016/17. A number of joint commissioning posts have been established and are being built upon, including senior posts that will provide the additional leadership that is needed to take forward integrated commissioning in Leeds.

IM&T – Technology will continue to support integrated working. The Leeds Care Record is a cornerstone of the city technology strategy. There are currently 1700 active clinical and professional users, inside and outside hospital. At present integrated team members with legitimate access rights are able to view hospital data, GP data and mental health data relating to their caseload. In 16/17 this will be expanded to include adult social care and community data. We also expect to begin including status 'flags' to ensure essential aspects of health and care are visible to those professionals that need to know. During 2016/17 hospices will begin to use improved functionality to increase their integration.

Within integrated teams community health staff will continue to use their core system more effectively, changing use in a phased approach from administrative use to clinical use, providing deeper electronic record facilities to services.

We will continue to strengthen information governance across the city with the on-going work of a cross-city Information Governance Group.

We also expect that analytical techniques and skills will continue to improve as we build upon the use of secure and anonymised linked data to ensure that commissioned services are planned with a robust evidence base and are evaluated for effectiveness.

*Reducing demand on NEA:*

The target for 2015/16 for NEA has not been met, so one key priority for 2016/17 is to turn this around within the Leeds system. The reasons for an increase in NEA are being reviewed by the System Resilience Group (SRG) who commissioned an external assessment of provider performance. Some out of hospital schemes funded by the BCF are beginning to have a positive impact on the whole system, it is hoped that they will contribute to the reduction of NEA in 2016/17. These are:

- Increased community intermediate care beds
- Homeless Admissions Leeds Pathway
- Targeted case management in primary care
- Reablement services
- Memory Support Workers

Contract negotiations with the Leeds Teaching Hospitals Trust have not concluded, the level of performance required for 2016/17 is a priority issue that is being discussed. Various actions internal to the Trust as well as services provided by others should contribute to reductions in NEAs for 2016/17. However, if the review that is being done by the SRG points to issues that may take longer to resolve, commissioners have set aside a contingency fund to ensure that system stability is maintained.

Commissioners recognise that bringing down NEAs is not purely a financial issue but is a system issue which needs to address change in practice as well as behaviour. This is the domain of our STP and within it these challenging issues are being addressed. The Leeds System Flow Programme has set out to bring about change that will have a positive impact on NEAs. Our STP says that "the 7 partner health and care organisations in Leeds are fully committed to improving System Flow, to provide services with capacity that matches demand, reduces the variation of service delivery, increases reliability and responsiveness to problems across organisational boundaries".

### 4.2 What change will the BCF bring?

The BCF will support the aims of the STP and CCG operational plans in 2016/17. It will enable the development of the STP and CCG operational plans by funding and coordinating those schemes that contribute to the aims of sustainable transformation. In particular the BCF will sustain those schemes that will contribute to reducing NEA, sustain the reductions we have achieved in DTOCS and sustain and extend the work we have done to integrate health and social care. The 3 Leeds CCG operational plans respond to closing the gaps identified in the NHS Five Year Forward View:

- Health and wellbeing;
- Care and quality; and
- Finance and efficiency.

The BCF will support those areas highlighted in CCG operational plans and will be used as an enabling fund in 2016/17. Sustaining the reduction in DTOCS, reducing NEAs and working collectively to improve system flow are key features of the operational plans that will be supported by BCF.

### 4.3 Risks to delivery (see Risk Log in appendix 1)

There are clearly some risks to delivery of our plan. We have learnt from year 1 of the BCF and put prudent mitigating actions in place to maximise our chances of success.

## 5. The BCF POOLED BUDGET

### 5.1 BCF funding for 2016/17

The BCF allocation for 2015/17 is £55.9 million, £1 million more than last year, however in real terms there is a reduction in the fund. This is due to the level of contingency that we believe is needed in the acute care sector as well as the national withdrawal of the Social Care Capital Grant and the ring fence around the Disabled Facilities Grant. Funding contributions have been agreed between the Council and the CCGs as follows:

| | |
|---|---|
| Total Local Authority Contribution | £5.6m |
| Total Minimum CCG Contribution | £50.3m |
| Total Additional CCG Contribution | £0 |
| **Total BCF pooled budget for 2016-17** | **£55.9m** |

The BCF allocation will be spent in these sectors in 2016/17

| | |
|---|---|
| Acute | £10.5m |
| Mental Health | £5.7m |
| Community Health | £16.9m |
| Continuing Care | £0.3m |
| Primary Care | £2.1m |
| Social Care | £19.9m |
| Other | £0.5m |
| **Total** | **£55.9m** |

In 2015/16 £18.01m from the BCF was allocated to protecting adult social care, for 2016/17 this has increased to £19.9m.

### 5.2 Risk sharing agreement

The Leeds Risk Share Agreement can be found in the BCF Partnership Agreement that was signed off in April 2015. See Appendix 2. This will be reviewed in light of contract negotiations with Leeds Teaching Hospitals NHS Trust and BCF contingency plans for 2016/17.

### 5.3 Impact on service providers

All service providers who have been affected by the reduction in BCF for 2016/17 were informed in time. Services that were meeting the requirements and goals of BCF and had the potential to be mainstreamed were advised to seek funding via the CCGs planning process for 2016/17.

# 6. CAPACITY TO DELIVER – WORKFORCE

## 6.1 Integration in 2015/16

Leeds is nationally recognised as one of the 14 pioneer sites in integration. Progress over the last three years has involved 1,200 practitioners across health and social care as well as professionals in other organisations in the statutory and voluntary sector.

In 2015/16, the co-location of staff in 13 integrated neighbourhood teams has been completed and includes district nurses, community matrons and social workers. The teams are aligned with GP practices and the team co-ordinators are supported by joined up service leaders across health and social care. Integrated neighbourhood teams provide the foundation on which to build better care.

Leeds has established a unique database of the Leeds paid health and social care workforce. In 2015, this identified a paid workforce of 57,000 staff and established that this will not be a sufficient resource to meet the anticipated future demands arising from a growing, aging population with more long term conditions. Initial change work regarding the workforce in 2015/16 has included:

- Agreement of a single, high level workforce plan between key health and social care partners and being promoted through a 'Working Together as One' approach.
- Multi-disciplinary team approaches between GPs, Primary Care, Third Sector and Integrated neighbourhood teams.
- First integrated apprenticeship scheme for health and social care as part of an approach to more generic multi-skilling in the unregistered workforce.
- Developing job role flexibility across health and social care contexts e.g. occupational therapists.
- Developing new roles such as social prescribers, community pharmacists, primary care physiotherapy clinicians, physician associates, clinical care co-ordinators, preceptee practice nurses.
- System wide recruitment campaigns to address immediate job shortages in areas such as nursing.

## 6.2 Plans for 2016/17

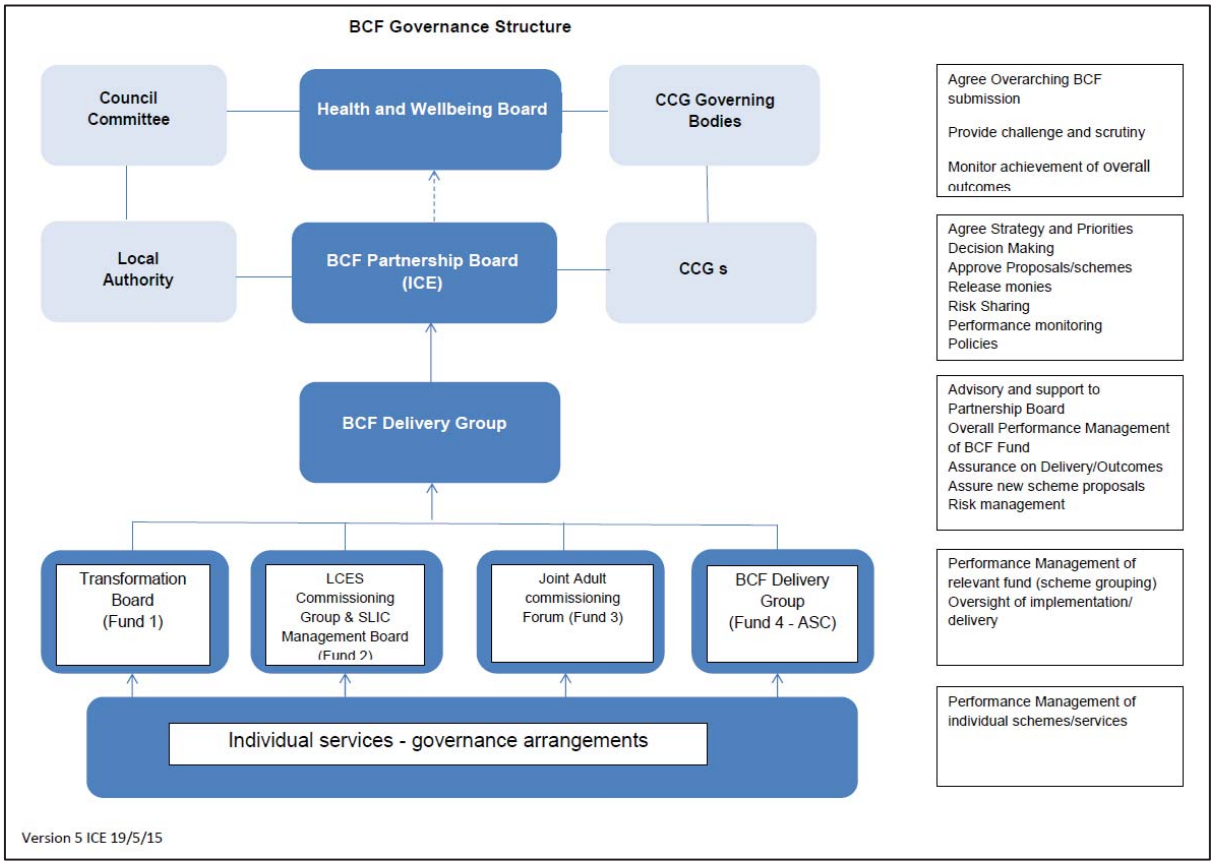
The Leeds STP will provide an overall direction of travel for the re-shaping of the Leeds health and social workforce moving forwards. Specific plans already in place include:

- Expanded and regularly updated Leeds health and social care paid workforce database to support implementation of the STP
- Remodelling of a workforces in localities to support model of care prototypes
- Greater integration of and multi-skilling of the unregistered workforce through a system wide approach to the use of apprenticeships
- Greater upskilling of staff to support strength and asset based approaches and the culture shift to a changing care model
- Pan-Leeds approach to workforce shortages that includes recruitment, sharing resources, transferability and increasing skill and experience mix.
- Further use and awareness of new and changing job roles.

## 7. GOVERNANCE

The BCF is managed by a robust governance structure with clear reporting lines and accountability processes. The diagram below describes this:

**Figure 2**



The BCF reports into the HWB. The Delivery Group is jointly chaired by the accountable officer for the CCG and the responsible chief officer for the Council and is responsible for assurance and overall performance management. The BCF Partnership Board which has the same membership as the CCGs' and Council's Integrated Commissioning Executive (ICE) is responsible for agreeing strategies and priorities and making decisions on spend within the BCF.

There is a methodical performance management process, the Delivery Group receives a scheme tracker and financial information every month and regular evaluation reports for each scheme. See Appendix 2 for BCF Partnership Board Terms of Reference.

## 8. KEY MILESTONES – PLAN OF ACTION

In 2015/16 appropriate Governance structures and reporting mechanisms were established, in 2016/17 The BCF Plan will complete the work that began in 2015/16 and ensure that the schemes are fully integrated into the wider transformation programme under the STP. A clear focus for BCF is reducing NEA and supporting innovation that began in 2015/16, in particular joint work and the use of technology. The following diagram represents the high-level milestones for the BCF in 2016/17.

Individual scheme milestones are held by each scheme, key delivery milestones can be found in section 9 under each National Condition. Trajectories for DTOC and NEA are contained in the Planning Template.

**Figure 3**

| | 2016 | | | | | | | | | | 2017 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
| **Aligning plans** | | | | | | | | | | | | | |
| BCF (Submission & S7 agreement) | | | | | | | | | | | | | |
| STP | | | | | | | | | | | | | |
| Operational Plans | | | | | | | | | | | | | |
| **Governance** | | | | | | | | | | | | | |
| HWB | | ◊ | | ◊ | | | ◊ | | ◊ | | ◊ | | ◊ |
| ICE/BCF PB | | ◊ | ◊ | ◊ | | | ◊ | ◊ | ◊ | ◊ | ◊ | ◊ | ◊ |
| BCF Delivery Group | ◊ | ◊ | ◊ | ◊ | ◊ | | ◊ | ◊ | ◊ | ◊ | ◊ | ◊ | ◊ |
| System Executive Group (Provider engagement) | | ◊ | | | | | | | | | | | |
| **Schemes Evaluation** | | | | | | | | | | | | | |
| **Assurance** | | | | | | | | | | | | | |
| **Delivery** | | | | | | | | | | | | | |
| **Monitoring (BCF Delivery Grp)** | | | | | | | | | | | | | |
| **Key** | | | | | | | | | | | | | |
| Alignig Plans (Submissions) | | | | | | | | | | | | | |
| ◊ Meeting Date | | | | | | | | | | | | | |
| Assuarance - Internal audit | | | | | | | | | | | | | |
| BCF Delivery Group | | | | | | | | | | | | | |

# 9. MEETING NATIONAL CONDITIONS

## 9.1 Plans are jointly agreed

Extensive consultation took place with health and social care providers when the original plan was submitted, see Appendix 2. Delivery of the BCF in 2015/16 has seen providers closely engaged with the wider transformation programmes in Leeds and contributing to change on an on-going basis.

This plan will be taken to the System Executive Group which has all health and social care commissioners and providers coming together to plan and manage the change agenda for Leeds. This will be the forum where leaders of provider organisations will be invited to engage with the BCF as it goes forward in 2016/17.

The Disabled Facilities Grant will be used to support the prevention agenda; the Housing Department lead has seen this plan and approved the use of the DFG. Further discussions are planned with Housing colleagues to explore opportunities for greater collaboration in future developments.

## 9.2 Maintaining provision of social care

The health and social care community in Leeds is committed to protect and maintain adult social care services. There is an understanding across health and social care partners of the critical contribution that social care 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 care 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. 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. This will continue to be maintained through the BCF and within the wider transformation programme in Leeds.

The approach taken in Leeds, which is consistent with the 2015/16 BCF, is not to restrict the protection of Social Care Services to the resources available within the BCF, but to consider protection of Social Care within the wider concept of the Leeds

Health & Social Care £. We are confident that the continuation of this approach will ensure the protection of Social Care in real terms at the levels of protection afforded in 2015/16 and that this will be in accordance with the 2012 Department of Health guidance.

### 9.3 Delivery of 7 day services

The Leeds CCGs are working with our Acute providers to plan for the delivery of 7 day services, specifically with Leeds Teaching Hospitals (LTHT). LTHT has established a 7 day services working group which the CCG's attend. The CCG's are assured that LTHT have an adequate delivery plan in place to move towards 7 day services in line with the National requirements. We have met with the national 7 day team and NHSIQ. There are ten national standards to achieve full 7 day services and LTHT are on track for achieving four of those standards as required in the National trajectory of milestones by April 2017. Nationally, full implementation of all ten standards is required by 2020, and we will work in 2016 / 17 with LTHT to assure ourselves of the plans for full delivery by 2020.

In addition the CCG's set up a 7 day services workshop and shared aspirations and learning between both, community, primary care and acute settings. The result of this workshop was that we needed to share current practice in 7 day services, so all organisations are informed of what is operational at a weekend in Leeds. The CCG's therefore collated and published a local 7 day services booklet called 'We are open' and this has been distributed around all the operational areas in health and social care organisations in Leeds (see Appendix 2). This booklet demonstrates that there are a number of services in community, mental health, social care and hospital settings that are already available over 7 days. All commissioning decisions, and service specification development now considers what services are required over 7 days.

Seven day service provision in Primary care is being considered via the Leeds West CCG pilot of 7day access to primary care. 19 Practices are open over 7 days plus twelve hour days in the week. The remaining 18 practices are open for twelve hours daily and many open on a Saturday morning. Evaluation is ongoing and includes impact on the whole system as well as patient's experience. This is a voluntary scheme for GP practices in Leeds West CCG, so no roll out trajectories are available. We understand that this is now the largest pilot of 7 day Primary care in the UK. We note the national aspirations for 7 day working in primary care and await further information and planning guidance from NHSE, but due to our current pilot and learning being shared across all three CCG's, believe Leeds will be in a strong position to respond to National guidance once it becomes available. We have also shared the emergent learning on the 7 day primary care pilot nationally at Conferences and had several visits to the CGG including Sir Bruce Keogh in early 2016.

In the community we have also developed various initiatives that offer 7 day access. We have a 365 24/7 Community Health service that is provided at Neighbourhood level. We have a joint referral / service access point to health and social care services via a Gateway.

The BCF has invested to ensure the Leeds Community Equipment Service is available 7 days per week which supports hospital discharge and enables more people to receive timely care in the community at weekends; avoiding unnecessary admissions. It has also enabled an increase of equipment being made available in peripheral stores and within the hospital as supplies can be maintained over the weekend; smoothing out the delivery and supply of the business over 7 days.

An additional investment in community beds has enabled the Community Bed Bureau to be available 7 days supporting access to community beds 365 days per year.

The aim of our drive towards 7 day services in Leeds is not only to create better access for patients but to facilitate alternatives to admission and support discharge of patients from hospital at a weekend. Information analysts provide detailed cross organisational data to monitor trends. Governance for the 7 day services is led through the Leeds System Resilience group.

### 9.4 Better data sharing

The BCF aims for last year have been met to a great degree, and will continue as a vital enabler in the wider transformation programme. Our aim is to ensure that right cultures, behaviours and leadership are demonstrated across our services, where information is shared in a secure, lawful and appropriate way to support better care. The following are key achievements that will be sustained and built upon in 2016/17.

Engagement with the public to gauge their perceptions on what information should be shared has taken place (known as Joined Up Leeds) and findings have been published, (See http://www.brainboxresearch.com/wp-content/uploads/2015/04/Summary-Joined-Up-Leeds-report.pdf).

We have participated in the National Data Guardian Review and produced and widely shared an Information Sharing booklet for patients and GP Practices.

Leeds has had the consistent use of the NHS number as a strategic goal for several years. Plans have been in place, funding has been provided and delivery has been achieved against those plans. The final areas to be addressed in 2016/17 are improving the regularity of updates in Adult Social Care and embedding the NHS Number in to Children's Social Care systems. This will be reflected in the forthcoming Local Digital Roadmap.

We have an excellent track record of interoperability between systems, as evidenced by the Leeds Care Record. We will use APIs where available but many health and care systems do not yet have such open features. A constraining factor is the maturity of APIs from our major provider systems. However, the use of APIs is a key strategic principle. We regularly exchange data between systems using a variety of well recognised techniques as follows:

- CTS and CDA messaging (e.g. discharge advice notes)
- MIG for data exchanges between GP systems and the Leeds Care Record
- Significant use of the InterSystems Integration Engine
- Open APIs being explored via the 'Ripple'
- Open Source Care Record initiative being hosted by Leeds.

We have established a city-wide Information Governance group, jointly chaired by senior IM&T managers from health and care. We have strong multi-organisational agreements as evidenced by the Leeds Care Record data sharing and data processing agreements.

These changes have allowed Leeds to implement integrated systems as evidenced by the Leeds Care Record. These systems have supported the integrated neighbourhood teams which deliver a core part of our vision which is to offer 'wrap around' services at a neighbourhood level. Leeds has produced a video that describes the impact that the Leeds Care Record has had on integrated care. We interview doctors, nurses and patients, who have seen first-hand the impact of improved information flows to support improved and more timely clinical decisions. (See you tube clip on this link - https://youtu.be/vuZlL38gRIM)

### 9.5 Joint approach to assessment and care planning

Case management across primary and community services has been focused on the top 2% high risk and vulnerable people needing community health services. This has been identified within the enhanced contract with the local provider and is reported via the contract reporting on CQUIN. In addition all who access adult community health services provided from the neighbourhood teams have a named care co-ordinator and receive case management. (See appendix 2)

Assessment and care planning forms part of the provision of integrated service delivery in Leeds. Our approach is based on our vision for health and social care where citizens are supported to become independent, building resilience for the future and helping people find their own solutions. Our emphasis going forward is on an asset based practice – looking at an individual's strengths, community and family connections, linking them into any additional, free to access support in their area and only then looking at whether they have any outstanding needs that require the support of statutory services. It's a change in emphasis from assessment and care planning to conversations with citizens, helping them to build their plans on how they live their life. To achieve this, the partnership needs to be broader so it moves from

a focus on neighbourhood teams based in health centres to local people and local workers making decisions on what makes for healthier communities, drawing on the entirety of resource in the area.

This shift in approach is planned to take place over the next 18 months but shifting the culture will take another 3 – 5 years of work to ensure it is fully embedded. Workforce development colleagues are supporting us with this and it forms part of the STP programme as well ('Working Together as One').

Health and social care services are developing a shared front door (currently co-located with a shared front door for hospital discharges but separate arrangements for community referrals). Once joined this will mean that people can phone in/refer when someone has a health and/or social care need and they will be triaged to identify the most appropriate initial support. The front door checks for current involvement so that local conversations can be held before a new service becomes involved and an integrated approach agreed. In this way any new assessments required can be built on existing information and in some instances the new referral may not be warranted as members of the team already involved can deal with the new request. This will be in place within the next 12 months.

**Figure 4 - Milestones for Shared Front Door**

| Task | Finish Date |
|---|---|
| Work with external referrers (GPs, YAS, Community Hubs) to improve quality of referrals commences | 22/03/16 |
| Performance work commences to develop front end KPI and performance reporting structure | 01/04/16 |
| Business Case for Integrated Health and Social Care Front Door updated and taken to BLTIS and DLT | 01/04/16 |
| 'To Be' workstreams agreed and Post April Milestones developed | 01/04/16 |
| Requirements for Leeds Care Record developed | 01/05/16 |
| Development work with Leeds Care Record completed | 01/09/16 |

Internal referrals between members of neighbourhood teams have been simplified so that people can become involved sooner. Regular case management meetings allow staff to raise concerns in a multi-disciplinary environment for any of the people currently on their caseload. In this way they benefit from different perspectives and can quickly pull other individuals into care planning. This is supported by regular conversations within co-located teams.

Dementia

The needs of people with dementia would be picked up as part of someone's unique plan and creative solutions found. Part of the 'culture change' will be to look at elements that should be everyone's business in which all should be skilled (including council one stop shop reception etc.) with the knowledge and information at hand to know when to call in specialists. This forms part of the transformation plan for integrated services. See Appendix 2.

For people living with dementia, families and carers, the Memory Support Worker (role described in Appendix 2 Leeds Dementia Pathway) will have a key role in co-ordinating the post-diagnosis care plan for people whose needs can be described as "supported self-management". As people develop more complex needs, we know that 'case management' is required.

Leeds and York Partnership FT are developing a model which will see them progress towards integration with community health and social care partners. LYPFT milestones are to have agreed a model by April / May 2016, and implemented a pilot by Nov / Dec 2016. This redesign and closer integration is based on a 'parity of esteem' approach and aims to address complex needs and, it is hoped, 'system flow' for the city.

Mental Health

Mental health is the focus of an initiative in one of our neighbourhoods (Armley) to build on the existing neighbourhood model to draw on a wider range of local resources to adopt an asset based approach to supporting people within their communities. The parity of esteem aims of Leeds is to ensure that all services respond effectively to the needs of people with mental health problems. To this end several initiatives have been undertaken, and form part of the wider transformation programme for mental health that is being implemented in 2016/17.

## 9.6 Agreement on the consequential impact of the changes on providers that are predicted to be substantially affected by the plans

BCF Plans for 2016/17 have not changed substantially from what was submitted in 2015/16. The impact on local plans has been affected by the failure to achieve the NEA target in 2015/16. Corrective action is being taken across the partnership to rectify this. The reasons for non- achievement could be attributed to a variety of causes, some within the control of the Acute Trust and others beyond their control. This is why the SRG is scrutinising performance with the aid of an external review report to understand the causes for failure and then establish a comprehensive plan to address the issues that maybe contributing to the increase in the cost of NEAs.

BCF plans have been subject to extensive consultation including political buy in. Please see appendix 2 for details. This refreshed plan has been seen by the Council's Executive Lead Member for Health Wellbeing and Adults who is also the chair of the Health and Wellbeing Board. She has been briefed on the plan going forward and will receive the final report before it is submitted on the 3rd of May for approval.

The BCF as part of the transformation programme in Leeds includes schemes that support mental health and as is the case across all planning in the City, Parity of Esteem is being actively implemented.

**9.7 Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care**

The greatest proportion of BCF funding goes to out of hospital services and will continue to do so in 2016/17. These services have supported the drive to reduce hospital admissions and to support people in their own homes and communities. It is difficult to attribute a direct cause and effect matrix to each scheme, but as these schemes mature in their development they are beginning to show value in addressing the aims of the BCF for 2016/17. The expectation is that collectively they will contribute to reductions in NEAs in 2016/17.

As the NEA target has not been met for 2015/16, we have decided to set aside a contingency fund capped at £7.5 million which will be used against any negative consequences of a failure to meet NEA targets in 2016/17. The details of this contingency fund is linked to current contract negotiations that are underway with the Acute Trust, until that is complete we will not be able produce a comprehensive plan.

If we are able to turnaround the current NEA performance then any money left in the contingency will be used to extend out of hospital services.

**9.8 Agreement on local action plan to reduce delayed transfers of care (DTOC)**

In October 2015 members of all partner organisations took part in a TDA Sponsored Rapid Development Event. The event resulted in an agreed action plan focussing on 4 areas to improve flow from admission to discharge as follows

a) New Referral for Supported Discharge Process underpinned by improvement to hospital IT system PPM+

b) New Referral Process for Physio and Occupational Therapy underpinned by improvement to hospital IT system PPM+

c) Improved system for ordering equipment – piloted using process for ordering pressure mattresses

d) Improving Communications – Between wards and other partners and patients and families

Following on from this action we will be working on a stretch target of an average of 364-400 bed days per week from a current base line of 490. This stretch target is expected to be signed off by the SRG in the next few weeks.

In Leeds the DTOC plan is set within the context of the overall System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge).

The plan for process improvement is within the context of SRG plans. Plans describe improving effective hospital management for timely and safe discharge. This includes the establishment and piloting of the Discharge to Assess process as well as the commissioning of increased bed capacity in winter to support transitional care.

The DTOC Target does not form part of NHS England requirements regarding CCG operational plans however our operational plans are clearly designed to ensure enough activity is commissioned to meet system pressures.

Plans for overall system resilience are agreed through SRG and as such, plans are agreed with providers who all attend SRG.

Responsibility, accountability and measures for assurance and monitoring all sit with SRG. A DTOC subgroup of SRG has been established to monitor progress with improving processes.

The SRG regularly reviews national guidance and best practices on DTOC and are actively working with NHS Improvement to ensure we learn from best practice elsewhere.

SRG has commissioned work from VCS to support flow through hospital. This includes the commissioning of Age UK to provide a Hospital to Home Service which supports patients to be discharged. In addition Age UK have been commissioned to support patients in making choices about care and residential homes to reduce delays associated with Choice.

Investment into out of hospital services are expected to support the maintenance of the DTOC trajectory in 2016/17.

## Appendix 1 – Risk log 2016/7

The risk log for 2016/17 has been reviewed and updated to ensure that the system responds effectively to the key risks that may emerge to the delivery of the BCF plan for 2016/17.

| **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* | **Overall risk factor** *(likelihood *potential impact)* | **Mitigating Actions** |
|---|---|---|---|---|
| Schemes geared towards reducing Non Elective Admissions do not have the level of impact that is expected | 2 | 4 | 8 | • Schemes monitored by the BCF Delivery group.<br>• Appropriate action will be taken to address any schemes not meeting targets.<br><br>Owner: Accountable officers and BCF Partnership Board. |
| Failure to achieve NEA targets | 3 | 4 | 12 | • The BCF Plan<br>• Close monitoring of the target by the System Resilience Group<br>• The financial contingency that has been identified and set aside.<br><br>Owner: Accountable officers, BCF Partnership Board and LTHT executive board |
| The withdrawal of the Social care capital grant and ring fencing of the DFG could limit our plans for infrastructure projects | 2 | 4 | 8 | • Discussions with Housing colleagues to explore collaborative work in the future<br>• Exploration of other capital funding options with the Council<br><br>Owner: BCF Delivery Group |
| Meeting the DTOC target | 2 | 3 | 6 | • DTOC Plan and strategy for sustained improvement<br><br>Owner: System Resilience group |
| Mainstreaming schemes into the wider transformation programme | 2 | 3 | 6 | • Schemes not funded by BCF in 2016/17 have been placed on the CCG operational planning process for 2016/17<br><br>Owner: Integrated Commissioning Executive |

**Appendix 2 – Reference documents (see attached)**

a) Case Management Framework
b) Extract from the Leeds BCF Partnership Agreement
c) BCF Partnership Board Terms of Reference
d) Engagement in developing the BCF
e) ‘We Are Open’ booklet
f) Dementia - The pathway in Leeds

Appendix 2a

# CASE MANAGEMENT FRAMEWORK

## What is case management?

Case management is a set of activities designed to assist patients/service users and their support systems in managing medical conditions and related psychosocial problems more effectively. The aim is to improve patients' health and long term social care status and reduce the need for inappropriate medical services. The goals of case management are to improve patients' functional health status and wellbeing, improve quality of life, enhance coordination of care and eliminate duplication of services.

## Definition

Case management is the identification of a professional from the neighbourhood team who will proactively coordinate the care and support of a patient/service user with complex health and/or social needs. By working in partnership with them, their family and/or carer(s) and bringing in additional professionals as appropriate, case managers will ensure that personalised plans and goals are set on the basis of the assessed needs, preferences and choices of the individual and reviewed as necessary.

## Key messages

All patients/service users who are in receipt of services from LCH community nursing and/or therapy or are an open active case to ASC will be case managed. Within LCH the case manager will be a senior member of the team – Band 6 or above. There will be different levels of case management where the most complex of cases may require discussion at a case management meeting. It is acknowledged that as patients' needs vary, so will the level of case management required. The case managers will be able to delegate responsibility to their more junior colleagues, yet the overall accountability will rest with the identified case manager. The aim remains that patients and service users are able to access the correct support at the time they need it.

- Case management is an established tool in integrating services around the needs of patients/service users
- Case management is a **targeted**, community based and proactive approach to care that involves case-finding, assessment, care planning, care co-ordination and review.

## Interventions include

- Anticipatory assessments
- Multi-domain assessment and planning
- Monitoring
- Co-ordination and delivery of care
- Self-management coaching
- Education and counselling
- Medication management

- Care transition support
- Contingency planning
- Evaluation and review
- Coordination of additional health and social services
- Community and third sector services referred to as needs identified
- Advocacy and negotiation
- Psychosocial support

**Agree common population**

The recommendation is a GP Practice Population- need partnership working with GPs to help to wrap care around patients.

**List of professionals currently involved in case management (type care)**

- Social workers,
- Community Matrons,
- JCMT Care managers,
- Physiotherapists and Occupational Therapists
- Registered Nurses
- Respiratory Team,
- Cardiac Team,
- Diabetes Team,
- Community Psychiatric Nurses.

**Enablers of case management**

- Case management meetings within Neighbourhood Teams (complex patients)
- Assigned accountability of an individual or team for the patients being case managed
- Patients/service users matched with a case manager with the right competencies
- Monitoring of caseloads to ensure that optimum care is received
- Promotion of continuity of care to reduce the risk of unplanned admission to hospital/long term care
- Support for self-care to empower management of own conditions
- Development of information systems that support communication
- Effective relationships with patients and key stakeholders
- Mentorship and supervision
- Joint case management when applicable (i.e. Nurse/Therapist, Nurse/Adult Social Care).

**Case Management Guidance**

Not all patients/service users should be referred to case management meetings. Cases should be complex, problematic or difficult to manager.

Appendix 2b

**Extract from the Leeds BCF Partnership Agreement**

THIS AGREEMENT is made on 1st April 2015

PARTIES

(1) Leeds City Council of Calverley Street, Leeds, LS1 1UR (the "Council")

(2) NHS LEEDS SOUTH & EAST CLINICAL COMMISSIONING GROUP (Co-ordinating Commissioner on behalf of Leeds CCGs) of 3200 Century Way, Thorpe Park, Thorpe Park, Leeds, LS15 8ZB,

NHS LEEDS NORTH CLINICAL COMMISSIONING GROUP of Leafield House, 107-109 King Lane, Leeds, LS17 8BP,

NHS LEEDS WEST CLINICAL COMMISSIONING GROUP of WIRA House, Suite 2-4, WIRA Business Park, West Park Ring Road, Leeds, LS16 6EB,

**SCHEDULE 4 – RISK SHARE AND OVERSPENDS**

Risk Management Arrangements & Financial risk sharing policy: Better Care Fund between NHS Leeds South & East CCG, NHS Leeds West CCG, NHS Leeds North CCG and Leeds City Council for the financial year 2015/16

Purpose:

It is recognised by all partners in the Leeds health & social care system that there needs to be a realistic and robust risk share agreement in place to mitigate the financial risk of over performance or non delivery of existing services funded through the Better Care Fund (BCF) and also through delay or failure to achieve the required outcomes.

Failure to deliver the planned reduction in emergency activity (resulting in a reduced non elective/A&E cost with our major acute providers) supported by increased investment in out of hospital care will create significant cost pressures for the whole system which will need to be resourced by all partners in line with the agreed risk share.

Partnership Agreement:

Partnership agreements provide an appropriate vehicle for sharing risk between the associated parties. The agreed principles for risk-sharing are:

(i) The financial impact of unpredictable incidents on system wide deliverables should be shared proportionality, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effective delivery of the schemes.

(ii) Where any impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the impact.

(iii) The BCF pooled funds need to deliver within budget including delivery of planned reductions in spend. The schemes should not create additional cost pressures in the Leeds health and social care system. Each pooled budget lead is responsible for ensuring pressures are mitigated in full within year.

This financial risk sharing agreement is part of the overall governance arrangements and management of the Better Care Fund and needs to be considered within this context.

1. For 2015/16 the resources will be held under a partnership agreement. This agreement will include two pooled funds (via Section 75), one hosted by the Local Authority and the other by the CCGs. BCF services have been allocated to either pooled fund based on the most appropriate lead commissioner. Within the BCF partnership agreement, non-pooled funds (nominal funds) will also be used as the partnership vehicle for services which are inappropriate for inclusion in a Section 75. The BCF Partnership Board will be responsible for approving virements between the various pooled/non pooled funds.

2. Contingency arrangements (circa £2.0m in 15/16) will be developed to meet a range of financial risks affecting the BCF e.g. effects of increasing demand, changes to legislation and those risks outlined in the BCF risk register. However in line with national guidance, the first call will be against the (risk) of failure to deliver the planned reduction in non elective admissions. In 15/16 this equates to £6.5m at 100% tariff, with the £2m contingency representing the activity at the 30% marginal tariff. The rules around MRET are subject to change potentially moving from 30% to 70%. This will therefore be managed through monthly monitoring of the non elective spend and whilst there are currently no plans to amend the overall BCF if the planned savings are not at the expected level then the BCF will need to be amended to ensure the non elective risk is accounted for through amending the existing schemes and increasing the contingency.

3. Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board). The financial values are outlined in the BCF Partnership Agreement (£55m comprising funds from both the CCG allocations and council funding).

4. The BCF Partnership Board under the guidance of the Health and Wellbeing Board will make joint decisions, within the limits delegated to its members by their respective organisations, about the best use of the Invest to Save Funding which currently equates to £8.4m to support integration and maximise reduction in acute admissions. BCF Partnership Board therefore will be responsible for the final agreement and detail behind these agreements which will eventually form part of the full partnership agreement for 15/16. The implementation and ownership of the Invest to Save schemes will be managed under the Transformation Board governance arrangements.

5. The main objectives of the risk sharing arrangements are to protect all parties in relation to performance of individual schemes and the aggregate measure of reducing emergency admissions. The BCF Partnership Board will be accountable and held responsible for ensuring that expenditure remains within the budget provision approved by each partner organisation and the Health & Well-being Board. The BCF partnership board may delegate this responsibility to the Pooled Fund Managers as described in the BCF Partnership Agreement and the specifications for each BCF Fund.

6. Financial monitoring requirements, budgetary control arrangements, and in year changes to the Better Care Fund, will be decided by the BCF Partnership Board and will recognise the different financial regimes of each organisation. This includes ensuring:

- Each of the pool and non -pooled funds are expected to operate within budget, and Pooled Fund Managers/Accountable Officers will be accountable and held responsible for that.

- Pooled Fund Managers/Accountable Officers will need to consider the full year effect of the commitments that they are making to ensure that the allocated budgets are not exceeded in future years.

- Pooled Fund Managers/Accountable Officers will need to ensure 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).

7. Contract and procurement decisions will be taken according to the scheme of delegation of the lead commissioner organisation for each fund.

8. BCF national guidance has stated that Care Act ring fenced funding has been provided. This funding will go directly to the council. If the council can deliver the Care Act obligations within this funding then the full funding will remain with Leeds City Council, whilst any additional pressures will remain the responsibility of Leeds City Council (in line with the principle that only funds within the pool count towards the risk share arrangements)

9. Any activities undertaken, which are not jointly agreed, will be undertaken at the risk of the individual organisation(s).

The treatment of Over and Underspends within the Overall BCF Pool:

10. The pooled funds will be managed at fund level and delegated to Pool Fund Managers. Non-pooled funds will be managed at service level and delegated to the Budget holder for each individual service. The £55m BCF will in effect be managed as four budgets plus the contingency as per the BCF governance arrangements.

11. Underspend/Over delivery of Benefits of the BCF within an individual pool – e.g. Slippage on the implementation of invest to save schemes, over delivery of QIPP savings or underspends within operational general schemes will be used in the following order:

a. Offset the failure to deliver the non elective planned reduction in spend in line with national guidance

b. At the discretion of BCF Partnership Board - against any over performance within the other pools.

c. Any remaining underspend will be distributed back to the four partners (LN, LSE, LW and LCC) based on in year contribution and delivery in year for that scheme.

d. If one party has significant in year pressures then it may be possible for the four partners to review this split and focus on supporting one of the partners on the assumption the funding would be repaid in future years.

12. Overspend/Under delivery of the Benefits of the BCF:

a. The Pooled Fund Manager (or Budget holder for non-pooled funds) will be held accountable for ensuring their overall fund remains in budget.

b. At the discretion of BCF Partnership Board - any underspends from other pools or invest to save schemes could be allocated to support a pressure in a pool

If no further mitigations exist in other pools or the contingency is exhausted then this would be a serious problem for the partners to resolve. The partners will need to provide in year funds to resolve the issue.

Non Elective Spend Within the BCF:

13. Non Elective Spend/budget within the BCF is reflected in the following schemes

a. £2m Contingency (against not delivering planned savings)

b. £2.8m Admission Units, (improve patient flow and reduce costs)

14. There are many schemes outside of the BCF within the CCGs that are focusing on reducing non elective admissions and it will be difficult to link a particular scheme to the impact (i.e. a BCF or a non BCF scheme). This will be attempted through monitoring of individual schemes.

15. The non- elective budget will be managed as follows.

a. 14/15 Expenditure - £116m

i. Overall Non Elective Expenditure - £109.5m

ii. Overall Assessment Unit Expenditure - £6.5m

b. Non Elective Plan 15/16 Plan - £114m

i. Overall Non Elective Plan - £107.5m

ii. Overall Admission Unit Plan - £6.5m

c. BCF Admission Unit Plan - £2.8m

d. BCF Contingency (Reflecting the planned reduction) £2m

16. It is expected the non-elective expenditure will reduce in line with the revised plan for 15/16. If the expected savings are met the value of the funds held within the BCF will either be reinvested or used as a cost improvement saving to be split between the partners based on the contribution made between the four partners. CCGs will retain any further underspends at CCG level.

17. There will be a separate and regular evaluation and review of schemes throughout each year which will help mitigate the risks for future years and ensure effectiveness and value for money.

18. The appropriate accounting standards will apply in relation to any joint arrangements that are put in place.

19. Each of the CCGs and the Local Authority will recognise its share of the pooled budget in its individual accounts and memorandum accounts will be produced. The pool and this agreement will be subject to the usual audit and annual reporting requirements, for which differences in accounting treatment will need to be recognised in line with auditor's advice. There needs to be a commitment to produce memos in line with all parties audit requirement

20. The BCF pool may be increased in 16/17 onwards beyond the mandatory level and the risk share arrangements will need to be reviewed in the light of any changes to this pool.

If any other organisations become part of the pool they must participate in the sharing of the financial risks according to this agreement

Appendix 2c

# Better Care Fund Partnership Board

# Terms of Reference

| | |
|---|---|
| **Version:** | DRAFT 1.21 |
| **Approved by:** | Leeds CCGs' Governing Bodies and Leeds City Council Executive |
| **Date Approved:** | |
| **Date Issued:** | |
| **Review Date:** | |

## 1 PURPOSE

The Better Care Fund (BCF) Partnership Board ('the Partnership Board) is a sub-group of the Leeds Integrated Commissioning Executive.

The purpose of the Partnership Board is to oversee the BCF partnership agreement between the Leeds CCGs and Leeds City Council and to monitor the Better Care Fund.

The BCF Partnership Board will act as a forum for reviewing and considering plans and proposals for BCF funding and promoting the agenda on integration.

The Partnership Board will make recommendations to the Health and Wellbeing Board in terms of the strategic planning for the Better Care Fund.

## 2 MEMBERSHIP

2.1 The Partnership Board will consist of senior officers of the Leeds CCGs and Leeds City Council:

**Leeds CCGs:**

- Clinical Chair and Chief Accountable Officer, Leeds North CCG
- Clinical Chair and Chief Accountable Officer, Leeds West CCG
- Clinical Chief Officer (Accountable Officer) and Chief Operating Officer Leeds South and East CCG
- Chief Finance Officer, Leeds South and East CCG (On behalf of the 3 CCGs)

**Or a nominated deputy**

**Leeds City Council:**

- Director Adult Social Care, Leeds City Council
- Director of Public Health, Leeds City Council
- Deputy Director, Adult Social Care Commissioning, Leeds City Council
- Director of Resources, Adult Social Care, Leeds City Council

**Or a nominated deputy**

**Other officers may be asked to attend meetings of the Partnership Board as required**

2.2 The Partnership Board will be jointly chaired by a CCG Chair and the Director of Adult Social Care, Leeds City Council

2.3 Other senior officers of the CCG and Council may be invited to the meeting as required.

## 3 QUORUM

3.1 The quorum for the Partnership Board shall be two CCG representatives and two Leeds City Council representatives.

## 4 VOTING

4.1 The Partnership Board will not be required to formally vote.

The Partnership Board will be expected to reach a consensus when agreeing matters of business. Where it is not possible to reach a consensus the matter will be referred to the CCGs' Governing Bodies/Council Executive Board for consideration.

## 5 SECRETARY

5.1 The support functions required to service the Integrated Commissioning Executive will be extended to include support to the Partnership Board.

## 6. CONFLICTS OF INTEREST

6.1 Declarations of interest will be a standing item on all meeting agendae.

6.2 Attenders who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chair of the meeting will decide the course of action required, which may include exclusion from participation in the discussion.

6.3 All declarations of interest and actions taken in mitigation will be recorded in the minutes.

## 7. FREQUENCY AND NOTICE OF MEETINGS

7.1 Meetings will be held at least quarterly but more frequently if required.

7.2 Items of business to be transacted and all supporting papers for such items for inclusion on the agenda of the Partnership Board need to be notified to the Chair of the meeting at least 7 clear working days (i.e. excluding weekends and bank holidays) before the meeting takes place.

7.3 The agenda and supporting papers will be circulated to all members of a meeting at least 5 clear working days before the date the meeting will take place.

7.4 With the agreement of the Chair, items of urgent business may be added to the agenda after circulation to members.

7.5 Minutes will be issued at latest 10 working days following each meeting.

## 8. REMIT OF THE COMMITTEE

8.1 All decisions made within the Partnership Board are through the authority delegated to individual members of the Partnership Board through their host partner organisation, and the governance of such decisions is through the mechanisms of those organisations.

8.2 The Partnership Board is authorised to create sub-groups or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Partnership Board remains accountable for the work of any such group.

## 9 DECISION MAKING

9.1 The Partnership Board is authorised within the limit of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

- Authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the partners to any Pooled fund; and

- Authorise a Lead Commissioner to enter into any contract for services necessary for the provision of services under an individual scheme

9.2 The following decisions are reserved for the CCG Governing Bodies and Council Executive Board:

- Approval of schemes beyond delegated limits
- Financial contributions and budgets
- Changes to the partnership agreement
- Budgets for individual schemes
- Virement and transfers beyond delegated limits
- Contract awards beyond delegated limits

## 10. RESPONSIBILITIES AND DUTIES

The Partnership Board will:

10.1 Provide strategic direction on the individual schemes

10.2 Monitor financial and activity information

10.3 Review the operation of the partnership agreement and performance manage the individual services

10.4 Monitor the implementation of and outcomes from individual schemes within the Better Care Fund

10.5 Review and agree annually revised schedules as necessary

10.6 Review and agree annually a risk assessment and Risk sharing arrangements

10.7 Request such protocols and guidance as it may consider necessary in order to enable each Pooled Fund Manager to approve expenditure from a Pooled Fund

10.8 Approve proposals/schemes within delegated limits

10.9 Approve release of monies in relation to approved schemes

10.10 Review quarterly and annual returns

10.10 Review and recommend plans for the BCF to the Health and Wellbeing Board, CCG Governing Bodies and Council Executive Board

## 11. REPORTING and ASSURANCE ARRANGEMENTS

11.1 The Partnership Board will report to the Governing Bodies of the Leeds CCGS and the Council Executive Board

11.2 Minutes from the Partnership Board meetings will be submitted to each partner organisation.

11.3 A quarterly assurance report on the implementation, delivery and outcomes of the BCF will be submitted to a specified group or committee within each partner organisation.

11.4 An annual report on the operation of the partnership agreement will be submitted to each of the Leeds CCGs' Governing Bodies, the Council Executive Board.

11.5 Quarterly reports and annual returns for the Better Care Fund will be submitted to the Health and Wellbeing Board

## 12. BCF DELIVERY GROUP

12.1 The Partnership Board will approve the terms of reference of the BCF Delivery Group which will provide advice and support to the Partnership Board

12.2 The Partnership Board will receive regular reports from the BCF Delivery Group

END

Appendix 2d

## ENGAGEMENT IN DEVELOPING THE BCF PLAN

### 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

# We are open seven days a week

We want to ensure that patients in the city are able to access **high quality and safe care** throughout the week. Responding to feedback from frontline professionals we have put together this brief guide. We want you to know about services that are available seven days a week that could help improve the patient pathway. In particular, this will mean safe transfers of care with appropriate services available to support patients moving from one care setting to another.

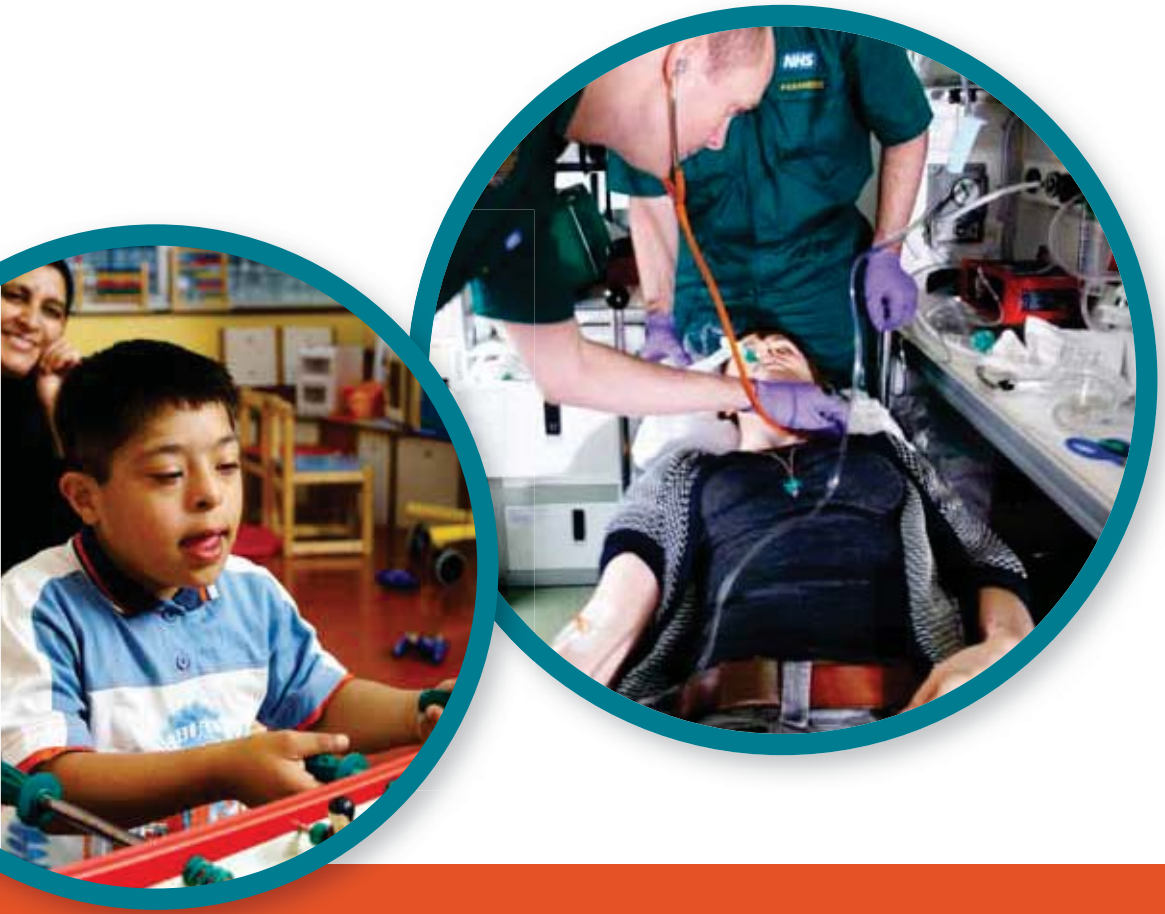




# Primary care - extended access

The city's three clinical commissioning groups (CCGs) are working closely with their member practices so that we can improve access to primary care (GP) services in Leeds. There are already examples of patients being able to access early morning, late evening and weekend GP appointments, especially in the west of the city.

During periods of extreme system pressures we work with our primary care colleagues to offer extended access. This helps us to meet patient needs and help cope with additional demand on services, particularly within the acute setting.



# Leeds Teaching Hospitals NHS Trust

As one of the largest hospital trusts in the country it is inevitable that we experience high levels of demand for acute services in Leeds. As a regional provider of a number of services there is an additional knock on effect to the pressures already experienced. A lot of work has been undertaken to help improve patient flow through the system. However demand is expected to continue to rise and work is ongoing to ensure we can respond to this pressure on services.

- All inpatient areas, accident and emergency department (AED) and treatment areas for urgent presentations are open out of hours and weekends. This includes diagnostic facilities and theatres
- Limited routine referral diagnostics open at weekends. Suggested patients and their families can be consulted if they want to be discharged on a Friday and return Monday as an outpatient for diagnostics - does occur now - but less routinely. Seven day diagnostics is a focus for the future
- Medicines reconciliation and pharmacy open weekends
- LTHT are making good progress in implementing seven day consultant review of patients. Consultant review occurs for majority of newly admitted patients at a weekend

Pharmacy department is open seven days providing medicine information, medicines reconciliation and supply services for inpatients. Call 0113 2065168, 9am - 7pm

# Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust offers a range of community services for adults and children from a range of settings including GP practices, clinics and patient's homes. Here are some services that offer seven day support.

## Adults

**SPUR (Single Point of Urgent Referral)**
Available 8am to 6:00pm / Tel: 0113 376 0369

**Neighbourhood Teams:** 13 multi-disciplinary (citywide) teams aligned to GP practice populations. They work in a person's own home to provide:

- Nursing care for those unable to get to their GP practice
- Rapid response to prevent avoidable hospital admission
- Short term care to achieve earlier discharge from hospital
- Support to maintain independence
- Support at / approaching end of life

Available 7am to 10pm / Referral via SPUR

**Night Nursing:** To meet nursing and care needs overnight.
Available 10pm to 8:30am / Tel: 0345 6050621

**Community Neurological Rehabilitation Service:** Early supported discharge for people who have had a stroke, working closely with neighbourhood teams.
Available 8:30am to 4:30pm / Referral via SPUR

**Joint Care Management Team:** Assess and care manage Leeds residents (aged over 65) with complex health and social needs in hospital. Also care manage people (aged 18+) in hospital and the community, if registered with a Leeds GP and funded though NHS Continuing Healthcare (this includes those with Fast Track funding).
Referral via SPUR

**Community Intermediate Care Beds:** Intermediate rehabilitation support provided as a 'step up' from community or' step down' from acute settings. Offer 24 hour residential / nursing care based on patient need. Access to beds is managed via bed bureau. Tel: 0113 295 5220

**Discharge Facilitators and Early Discharge Assessment Team (EDAT):** Works with Leeds Teaching Hospitals NHS Trust (LTHT) to support discharge and prevent admission including support for people at the end of life.
Contact: LTHT ward staff

**End of Life Care Home Facilitators:** Additional support for patients at or near end of life in care home setting (residential and nursing).
Tel: 07736 480991 (08:30 to 16:30, seven days a week)

**Community Intravenous Antibiotics Service (CIVAS) and Community Intravenous Diuretics Service**
Tel: 0113 8431764 / 07960 727267 (08:30 to 16:30 on weekdays)

## Children

**Children's Nursing (CCN) Service:** Provide high quality nursing care, short breaks and support in partnership with other professionals and agencies to children with a wide range of health problems. Some areas of the service cover seven days and there is some very specific 24/7 cover.
For further information contact: 0113 2728644 (office hours only)

**Child and Adolescent Mental Health Services (CAMHS):** We provide 24/7 inpatient services and occasional outreach service at weekends for vulnerable young people under 18.
Visit: www.leedscommunityhealthcare.nhs.uk for more information

# Leeds and York Partnership NHS Foundation Trust

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides secondary mental health and learning disability services to people of Leeds and some specialist mental health services across the Yorkshire and Humber region. Visit www.leedsandyorkpft.nhs.uk for more information.

### Crisis Assessment Service

LYPFT has a 24/7 Crisis Assessment Service providing a same day crisis response in the community where required. Referral and Advice line: 0300 300 1485

### Acute Liaison Psychiatry

The acute laison psychiatry service (ALPS) offers 24/7 mental health assessments covering the emergency department and self-harm assessments on the acute hospital wards.

For LTHT staff contact the clinicians at any time please bleep through LYPFT switchboard on 0113 85 55000

Primary care - all enquiries from primary care should be directed to Liaison Psychiatry admin on tel: 0113 85 56730 / 56731 / 56762

### Older People's Liaison Psychiatry Service

There is a dedicated older people's liaison psychiatry service that operates seven days a week, 9am-5pm. It provides mental health assessments in the emergency department and on acute wards. Staff can be contacted on 0113 206 7147

At weekends and on bank holidays the older people's service provides limited cover for urgent referrals. You can contact the team on: 07949 102129. Outside of these working hours all referrals for people 65 years and over will be directed to the ALPS service.

### Medical Cover

LYPFT provide 24/7 medical cover. Outside of normal working hours this is through an on call rota and the on call psychiatrists can be contacted through LYPFT switchboard. Tel: 0113 85 55000

# Leeds City Council Adult Social Care

For a number of patients additional support will be required through Leeds City Council's Adult Social Care. There are a range of services available to support the safe discharge of patients throughout the week, including the weekend. This is not restricted to care services but also Leeds Community Equipment Services.

## Here's a list of services that could help you throughout the week:

- Leeds Community Equipment Services running 8am-6pm Monday to Friday and 8am-4pm on weekends
- Community support service for older people
- Assisted Living Leeds - joint with Leeds Community Healthcare NHS Trust
- Homecare Reablement Teams - 8am-10pm seven days a week (5pm-10pm is phone support only). Please note does not currently take new referrals at weekends
- Emergency duty team
- Domicillary care
- Telecare and mobile response works 24/7 (receive 300,000 calls a month)

Call 0113 222 4401, 9am - 5pm, Monday to Friday

# Specialist Palliative Care

Specialist palliative care services are available in Leeds at St Gemma's Hospice, Wheatfields Hospice and Leeds Teaching Hospitals NHS Trust.

Both hospices offer an inpatient unit, day services and community services. Inpatient units at St Gemma's and Wheatfields are open 24/7, taking admissions on weekdays and also taking limited admissions at the weekend.

Specialist palliative care community nurses are available seven days of the week providing telephone and face to face advice and support for patients, families and professionals. This service operates from 8.30am to 5pm. There is a reduced weekend service provided by one clinical nurse specialist in each team.

Specialist palliative care clinical nurse specialists are available in the acute trust seven days of the week providing telephone and face to face advice and support for patients, families and professionals. This service operates from 8.30am to 5pm. At the weekend the service is provided by one clinical nurse specialist.

Advice is available outside these hours from the nurse in charge of the inpatient unit in each hospice for patients, families and professionals. A palliative medicine consultant is available to provide specialist medical advice - the rota and contact details are available via St James's University Hospital and hospice switchboards.

Wheatfields Hospice Therapy Team provides a seven day rapid response service.

For information about how to refer to any of these services, please phone the hospice.

**Wheatfield Hospice** Tel: 0113 2787249

**St Gemma's Hospice** Tel: 0113 2185500

Produced by the NHS in Leeds and Leeds City Council. February 2016.
Contact details correct at the time of going to print.

Please note that the navigation bar & web links do not work in this version of the PDF

NHS

NHS Leeds Clinical Commissioning Groups
Leeds Integrated Dementia Board

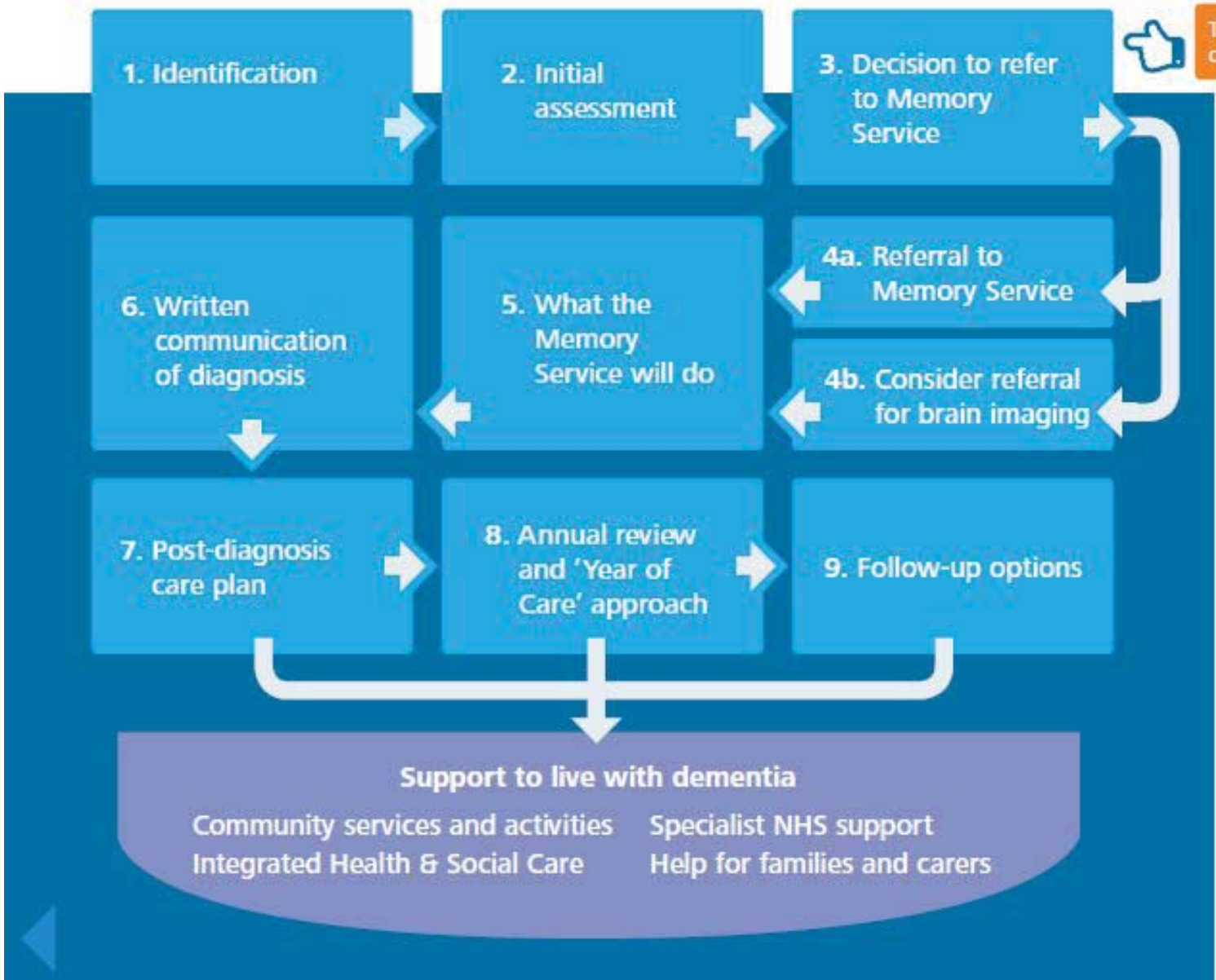
# Dementia - timely diagnosis, care planning, and support for well-being. The pathway in Leeds

**This document is a PDF optimised for viewing on a computer or tablet using Adobe Reader.**

You can use the navigation bar across the top of the screen to jump directly to different sections, as well as using any web links to visit external resources.

Version: 1.0
Date: 5th February 2016

# **Dementia** - timely diagnosis, care planning, and support for well-being. The pathway in Leeds




## Resources

A Support through the process/useful resources

B The Memory Support Worker role

C Note on dementia medication monitoring

D Care planning and review checklist

# Support through the process

**You can refer to Memory Support Worker for help before diagnosis**

- people with memory problems who need practical or emotional support to access diagnosis
- the person is not ready or willing to seek diagnosis, but family/friends/carers may need help
- the person is seeking diagnosis, and support is needed whilst waiting

# Useful resources

**Awareness and understanding of dementia - for everyone**

- 'Dementia Friends' awareness campaign
- NHS Choices: dementia diagnosis
- Alzheimers Society *'Worried About Your Memory?'*
- Alzheimers Society - 'Dementia Guide'

**Local support and services - for everyone**

- Living with dementia in Leeds - information page (see 'Documents' tab for useful leaflets)

**Resources mainly for professionals**

- e-learning package: Social Care Institute for Excellence - open dementia programme
- *'Worried About Your Memory'* poster and leaflet - eg. for clinics and surgeries
- Dementia Revealed: What primary care needs to know (NHS England, 2014)
- Helping you to assess cognition: A practical toolkit for clinicians (Alzheimers Society / NHS England / Royal Colleges - 2015)
- Leeds guideline for behavioural and psychological needs in dementia (2013)

# 1 Identification

**People with memory problems and possible dementia are identified throughout the NHS and by awareness-raising initiatives:**

- Patient and/or family may initiate concerns;
- Alzheimers Society *"Worried About Your Memory?"* campaign
- Awareness-raising in NHS Healthcheck (age 65-74)
- Screening in primary care long-term condition reviews (follow dementia DES)*
- Screening and assessment in acute hospital and community services*

*These screening processes include initial assessment & consideration of referral to memory service.

**A Timely Diagnosis**

"We should respect the decision of patients and families to present themselves at the time that is right for them. We can, gently and sensitively, nudge people towards thinking about their memory, but there is no justification for ambushing them."

**What Is Normal ?**

"It is normal to have occasional memory lapses and to lose things.
It is normal to forget why we have gone upstairs, or to come back from a shopping trip without the very thing we went for.
It is normal to have to search our brain for a name, sometimes.

"Our normal memory may suffer, from time to time, from impaired function through inattention, information overload or mild depression but, unless there is something wrong, we retain a huge store of general (semantic) knowledge, an ability to plan and manage our affairs and, under normal circumstances anyway, we retain our orientation in time and place."

*from Dementia Revealed: What primary care needs to know (NHS England, 2014)*

# 2 Initial assessment

- **History-taking from patient and family (or other 'informants') is the most important information**, supported by:
- Simple cognitive test (e.g. GP-COG / 6-CIT / AMTS - these are included on templates)
- Blood tests: FBC, calcium, glucose, renal and liver function, thyroid function, serum vitamin B12 and folate levels (for GP practices, these are identified in QOF DEM005).

*Blood tests are to investigate potential reversible causes of cognitive problems. The decision to refer to Memory Service is usually made prior to results coming back. This is to avoid undue delay; Memory Service can see results on Leeds Care Record/ICE.*

Consider:

- Depression screening and / or assessment of anxiety, if indicated. Depression and anxiety can be linked to dementia, or present with some similar symptoms. Seek specialist advice if required.

**Tips**

- on 'ICE' system, the blood tests can be ordered as a single group: from *Pathology Requesting* screen, click on *QOF Test Panels* and then select *Dementia*.
- if considering referral to Memory Service (steps **3** & **4**), and it seems that the patient might forget or miss appointments, ask if the person consents to arrangements being made directly on their behalf with family member/ carer, and communicate this consent to the Memory Service.
- **For people with a learning disability (intellectual disability):** symptoms of dementia can be very different, often presenting with changes in functional ability with or without behaviour change, and may require specialist assessment. If dementia is suspected, please seek advice from, or refer to, the specialists within the Community Learning Disabilities Team.

# 3 Decision to refer to Memory Service

**Frail older people where presentation of dementia is clear and no other reason to refer** - specialist referral may not be necessary.
*"...patients who present with more advanced symptoms of dementia... may be diagnosed and managed in primary care..."*
(Extract from RCGP & RCPsych guidance)

- GP can diagnose and record on practice system. The Diagnosing Advanced Dementia Mandate supports this, particularly for people in care homes.
- Refer to memory service if required eg. to consider prescribing; OR if management depends on diagnosis of sub-type.
- Consider for avoiding unplanned admissions, and/or referral to Memory Support Worker
- Consider Care Homes Liaison Service CMHT if needs and risks are complex.

**Delirium** may be slow to resolve eg. after acute infection/hospital admission, and make it hard to assess underlying cognitive impairment.

- Refer to Memory Service if cognitive decline preceded acute event;
- Monitor & review if cognition was normal prior to acute illness.
- Seek advice if required or history unclear - Memory Service or Community Geriatrician.

**If history OR testing indicates cognitive impairment**

- memory loss; difficulties with thinking, problem-solving or language;
- OR changes in behaviour, mood, personality, hallucinations not otherwise explained.
- OR if indicated by cognitive test score.

**Offer referral to Memory Service**

NB. if there are clear indications from history-taking, **do refer** - a 'normal' cognitive test score does not rule out dementia.

**If there are support needs for the patient or family/carer** whilst waiting to be seen by Memory Service, or if help is needed to eg. remember or attend appointments: involve Memory Support Worker and / or refer to other community services.

# 4a Referral to Memory Service

**Include:**

- Individual and family/social circumstances, history of concerns;
- Cognitive test scores;
- Medical history and current medication;
- Confirm that blood tests have been requested (p5), but do not await results if they are not yet available. Memory Service clinicians can view blood test and scan results on Leeds Care Record/ICE.
- **Consider referral for brain imaging (usually CT head scan) when referring to Memory Service (see step 4b).** This avoids serial waiting times which occur if memory service make the referral for a scan.
- If given, communicate consent for Memory Service to make arrangements directly with appropriate family member/carer.

**Resources and notes:**

- LYPFT referrals via Single Point of Access; other providers using local arrangements.
- Information for patients and families/carers: NHS Choices: dementia diagnosis
- Leeds now has Memory Clinics hosted at local GP practices - at least one for each old-age psychiatry consultant (LYPFT and TEWV). These offer more local options as an alternative to specialist hospital/outpatient locations.
- If support is needed whilst waiting; or people need practical or emotional support to access diagnosis: involve Memory Support Worker.

# 4b Consider referral for brain imaging

**Refer for CT head scan** at the same time as referring to Memory Service, to avoid serial waiting times. This is to inform the diagnosis, including type of dementia, and to exclude eg. injuries/tumours:

**Unless**

- current scan already available (e.g. carried out in hospital) OR;
- contra-indicated (e.g. frailty, declined by patient)

CT scans are quick to perform (1-2 minutes) and the large majority of patients tolerate it well.

**Consider referral for MRI scan**/consult with old-age psychiatrist for patients:

- with unusual or atypical presentations/acute or rapidly progressive dementia
- in the younger age group (generally < 65 years)

NB. MRI can be poorly tolerated by some patients. It takes 25 minutes to perform and the patient has to lie perfectly still in a tunnel with their head restricted within a helmet (the MRI coil). The scan produces an extremely loud noise which can be frightening and disorientating for the patient.

It is hoped to simplify CT scan requests for dementia diagnosis on the ICE system; in the meantime the following guidance is recommended:

"Scan reports are very dependent on the information provided by the requesting clinician. Key details about the patient should include: age, duration of memory problems, symptom progression, presence or absence of vascular disease … seek specific clarification on the presence of medial temporal lobe (hippocampal) atrophy, significant vascular ischaemic change and the presence of other intracranial pathology such as tumours.

An example request:

*80 year old with 3-year history of short term memory difficulties. Vascular risk factors include history of hypertension. Need to clarify the presence of significant vascular ischaemic changes, medial temporal lobe atrophy (hippocampal atrophy) or space occupying lesion."*

Guidance on Neuro-imaging in Dementia - Yorks & the Humber Strategic Clinical Network

# 5 What Memory Services will do

**Memory assessment and diagnosis**

- Further information-gathering from patient and family/carer
- Specialist cognitive testing (usually Addenbrooke's Cognitive Examination - ACE III)
- Review neuroimaging report (visible via Leeds Care Record for LYPFT)
- Consider further brain imaging
- Diagnosis (by old-age psychiatrist).

**Immediate post-diagnosis**

- Formulation of medical, psychological and social needs
- Initiate, review and titrate medication where appropriate
- As appropriate, offer of group or 1:1 nursing/OT/psychology interventions e.g. Memory Group, Cognitive Stimulation Therapy
- Offer *"Dementia Guide"* and *"Living With Dementia In Leeds"* leaflet, and other information according to individual needs and wishes
- Offer referral to Memory Support Worker.

# 6 Written communication after diagnosis

**The Memory Service will**

- write back to the referring GP on a standard letter format, including:
  - Diagnosis code in ICD, SystmOne and EMIS formats
  - Summary of prescribing , treatment, interventions
  - Recommendations for follow-up
- Copy to patient and carer, subject to informed consent.

*This standard is agreed with LYPFT; GPs referring to other providers may receive similar information in a different format.*

**GP practice - on receipt of diagnosis letter**

- Record diagnosis accurately, to ensure that the coding of dementia diagnosis will show on GP register (QOF - DEM001)
  *GP practice admin staff should seek advice if correct coding is not clear.*
- Continue with any recommended prescribing, as initiated and titrated in Memory Service
- Consider for avoiding unplanned admissions
- If 'Mild Cognitive Impairment' (MCI) is diagnosed, ensure this is flagged for review annually, or as recommended (unless Memory Service are reviewing). 10-15% of people diagnosed with MCI go on to develop dementia.

For any problems with coding dementia diagnoses on GP systems, please refer to NHS North Guidance on Dementia & Delirium Coding

# The Memory Support Worker

This role was introduced in October 2015.
Memory Support Workers will:

- support people with memory problems to overcome practical and emotional barriers to seeking diagnosis, and / or families when the person is reluctant to seek diagnosis
- help people and carers connect to support if required during the diagnosis process
- offer a visit shortly after diagnosis; support to adapt to and live with dementia; inform about and connect to local services and networks
- screen for frailty and falls risk, and consider other physical health issues including those linked to avoidable hospital admissions
- be a named contact for the patient and family
- work closely with GP practices, including sharing care plans and follow-up from annual review.

Memory Support Workers, with the agreement of each GP practice, access GP practice systems (SystmOne, EMIS).

This makes it easy to take referrals as direct requests from practice teams; and to share information and care plans following interventions.

# 7 Post-diagnosis Care Plan

The Memory Support Worker will:

- complete a simple care plan document
- share it with patient and family/carer, and GP (subject to consent and capacity)
- check that care plan completion is recorded on GP dementia DES template
- check ethnicity coding is recorded and correct on GP system.

**The Care Plan will include and share information about:**

- physical, mental health and social needs and include referral/signposting to local support services
- where possible and through encouragement, include a recording of the patient's wishes for the future
- record discussion of permissions for the practice to speak directly with family/carers
- offer health check to carer(s)/inform carers' GP practice.

*(This meets 'advanced care plan' requirement of the Dementia DES)*

- prevention of unplanned hospital admissions. Leading causes for people with dementia are falls/fractures; respiratory, urinary and kidney infections
- names of family/friends trusted by the person to help and advocate; consider need for advocacy services
- communication needs and how to meet them eg. reminders about appointments; best approaches for conversations. (cf. NHS Accessible Information Standard).

# 8 Annual review and 'Year of Care' approach

Monitoring in primary care - the annual review (QOF DEM004)

- **Recommended: the Leeds 'Year of Care' approach** enables a 'whole-person' approach to how the person and family / carer are living with dementia alongside other long-term conditions
- This approach encourages and support people to decide goals and actions to achieve them
- The Year of Care review template is designed so that QOF annual review requirements can be checked off for each long-term condition
- Alternatively, a 'standalone' dementia review can be completed.

Many patients coming for review will not have a post-diagnosis care plan in place. Consider offering a referral to Memory Support Worker if a more in-depth conversation about living with dementia would be helpful.

**Note on Memory Service involvement**

- will continue active involvement with those patients with dementia, or with mild cognitive impairment, who require specialist biopsychosocial interventions (including those with associated behavioural and psychological symptoms of dementia and significant risk history)
- will no longer see patients solely for the purposes of routine medication monitoring
- will respond to requests for advice and re-referral when changes in need and risk are identified in primary care and elsewhere.

# Note on dementia medication monitoring

The dementia drugs (Donepezil, Galatamine, Rivastigmine and Memantine) are now classified in Leeds as "Amber Level 2" – initiated by specialists, with little or no drug monitoring required.

- The main reported side effects for donepezil, rivastigmine and galantamine (the 'Cholinesterase Inhibitors') are loss of appetite, nausea, vomiting and diarrhoea. Other side effects may include muscle cramps, headaches, dizziness, fatigue and insomnia.
- The side effects of Memantine are less common and less severe. They include dizziness, headaches, tiredness, raised blood pressure and constipation.

Side effects of dementia medication usually occur early in treatment and are picked up by Memory Services during the initial stabilisation and review period. For concerns about possible side effects, seek advice from Memory Service.

# Care Planning and Annual review - checklist

This checklist is to support clinical judgement; cover an item if it is relevant for the patient and carer.

- The review is essentially a helpful conversation with the person and family / carer, about how they are living with dementia, to agree goals and actions to achieve them.

**Physical** - consider:

- any problems with balance, falls risk, frailty; independent living / managing activities of daily living.
- whether medication being taken appropriately.
- prevention of unplanned hospital admissions. Leading causes of unplanned admissions for people with dementia are falls / fractures; respiratory infections; urinary and kidney infections

*Consider for "2%" admission avoidance planning; community services as appropriate - eg. falls services, eating and drinking team, social worker, community matron, community geriatrician.*

**Psychological**

- how is the person coping emotionally with the condition?
- changes to memory, mood, behaviour; concerns about boredom and frustration.

*Consider seeking specialist advice/referring to Memory Service regarding risky or aggressive behaviours.*

**Social**

- social life, activity and occupation.
- family and wider support networks.
- changes to communication needs.

*Consider involving Memory Support Worker or social prescribing service*

**Carer/significant others**

- How well is the carer coping? Are they getting a break from the caring role?

*Consider carer support services (eg. Carers Leeds) - offer carer health check.*

# 9 Annual review - options for follow-up

Any or all of the following may be appropriate, following annual review or at other times when changes or concerns come to light:

| | | | |
|---|---|---|---|
| **Concerns about** | **Social isolation, lack of networks, family/carer strain, need to discuss options and navigate the system, boredom.** | **Behavioural and psychological risks, consideration of dementia medication changes, concerns about side effects.** | **Other concerns about the progress of dementia, physical health, effects on independence/daily living/self-care.** |
| **Consider** | • Memory Support Worker<br>• Carers Leeds<br>• Social Prescribing<br>These services can use their local knowledge of community support to identify the right help. | Refer to secondary mental health services:<br>• Advice from, or referral back to, Memory Service<br>• Other specialist teams, eg. Care Homes Liaison, CMHT. | Options include:<br>• Integrated Neighbourhood Team, including social care needs assessment<br>• Community geriatrician<br>• Falls services<br>• Eating and drinking team<br>• End of life care. |