Supplementary Information
Leeds Better Care Fund

Introduction

The total value of the Leeds Better Care Fund (BCF) is in excess of £55million. It is a fund of a size that can make a real difference to health outcomes for patients, service users, their carers and their families and we are determined that this money is spent in such a way to support our ambition to go 'further and faster' on our journey to integration to realise this difference. The concept of the Leeds £ (a common currency that runs through all of health and social care services in the city) is already well established, and the establishment of the BCF signals that this is now being brought into reality.

2014/15 will be used as a shadow year to "pump prime" the Better Care Fund proposals, to help ensure that the city will benefit from and be able to maximise the opportunities from the BCF as soon as possible, in line with both our aspirations and our Pioneer status to go further, faster.

How the fund has been divided

In order to manage the fund, we have made the decision to sub-divide our total amount into a schemes that support existing and well-established jointly commissioned and/or jointly provided services through recurrent funding that is already committed, and taken the opportunity to develop new schemes that provide further "invest to save" opportunities through non-recurrent funding. Schemes of recurrent and non-recurrent funding have been separated below into two tables.

Table 1. Recurrently funded schemes 2014/15

Scheme No.	Name	Description	Investment	Return	
			Value £000	Min £000	Max £000
01	Reablement services	This funding supports the city's reablement services and one of the intermediate care bed facilities. It is already matched by contributions from the city council. Funding in this scheme is designed to supports patients to return directly to their own homes following unplanned admission – be it directly from the hospital or via the use of an intermediate care bed. These facilities support patients to move through the system and reduces pressure on discharge from the acute sector, maximise independence or avoid unnecessary admission completely.	4,512		
02	Community beds	This scheme is focussed on enhancing our community services to prevent acute admission and facilitate discharge. This funding supports a network of intermediate care beds and services. The beds act to facilitate prompt discharge and reduce length of hospital stay. For some patients they can also be used as a "step up" service to prevent acute admission.	5,299		

03	Supporting Carers	Part of the existing transfer of CCG funds to social care is to support carers. This includes initiatives to support carers supporting people with dementia, those that have been recently bereaved and respite care opportunities (both residential or at home). During the course of 2014/15 it is our intention to create an s256 agreement so these services can be delivered as part of our integrated care system.	2,058		
04	Leeds Equipment Service	This is the funding for the Leeds equipment service. The service helps users and carers to stay safe and independent at home, preventing hospitalisation. The service is jointly commissioned and run by health & social care services.	2,300		
05	3rd sector prevention	Health and social care services across the city are also supported by the voluntary and 3rd sectors. There are a range of organisations commissioned to provide support services including frail elderly, those with a physical disability, hearing and sight loss, dementia, stroke and advocacy services.	4,608		
06	Admission avoidance	In order to break the cycle of increasing admissions to hospital the health and social care across city recognises that it needs to invest in more pro-active and preventative care, especially for the frail elderly. Once someone has been admitted to hospital we need to invest more and ensure that the follow up care arranged for patients is going to support them to remain out of hospital in future.	2,800		
07	Community matrons	Currently community matron services in the city are funded by CCGs and are part of the integrated neighbourhood teams. By moving this funding to the BCF it will support the continued integration of this service into social care services.	2,682		
08	Social care to benefit health	This is the NHS England transfer from health to social care for 14/15. This fund is to be used to enhance social care services that have a direct impact on health and care for Leeds people.	11,850		
09	Disabilities facilities grants	Nationally agreed health funding to support local authorities to make modifications to homes for disabled people. Evidence shows investment in these grants supports people to live independently, reduces admissions to acute/community beds and facilitates discharges.	2,958		
10	Social care capital grant	This smaller scheme is to fund small capital and infrastructure projects across the city that support the integration agenda and have a benefit for both health and social care.	1,844		
11	Enhancing primary care	From 2014/15 the new GPs contract will incentivise GPs to take a case management approach to the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding will be used to enhance services to support the management of this patient cohort.	2,141		
		TOTAL	**43,055**		

Table 2. Pump priming – invest to save schemes 2014/15

Scheme No.	Name	Description	Investment	Return	
			£000	£000	£000
	Eldercare Facilitator	This new role will focus on patients with dementia and other frail elderly patients with mental health illnesses. The facilitator will link to the existing neighbourhood integrated teams to meet the demand for increased diagnosis, support memory assessment and work with people and carers post-diagnosis to provide support and sign-posting to local services not hospitals.			
	Medication prompting - Dementia	Improve medication prompting for people with memory problems to avoid hospital admission caused by adverse reaction and potential multiple conditions treatment/co-morbidities. Adherance to proscribed treatment to maximise clinical effectiveness and health benefit.			
	Primary care proactive management	Provision of enhanced support to Care Homes and the housebound through GP visits and use of teleconferencing/telehealth/telemedicine facilities – targeted at those locations where referral rates to hospital are highest.			
	Falls	During the course of 14/15 work will be undertaken to review the existing falls services, better identify the gaps in service and recommend where investment would make the most difference. Existing service models could subsequently be developed to respond urgently to people who have had a fall but don't necessarily need acute hospital care but who can't be left alone at home. There are several initiatives already in place in other parts of Yorkshire run by the Yorkshire Ambulance Service and the voluntary sector that would need further consideration before commissioning.			
	Expand community / intermediate beds	The city is in the process of reviewing the entire bed base in all sectors. In order to continue to reduce the number of acute hospital beds, capacity in effect needs to shifted into the community. This scheme will be used to pump prime additional community beds for both intermediate (with nursing) and temporary (non-weight bearing) to enable appropriate and timely discharge of patients from hospital and avoid admissions. This could include increasing staffing ratios to support flow through the system.			
	Enhancing integrated neighbourhood teams	This scheme will look to extend and enhance the role of the existing neighbourhood teams in a range of ways, to improve their focus on streamlining discharge and proactively manage patients in the community. More specifically this will include: a)Leeds Equipment Service to be open at weekends – 7 days/week b) Extend hours for the Early Discharge Assessment Team based within A&E c) Roll out the Early Discharge Assessment Team model to further hospital wards d) Extend the home care service to support 24/7 support for service users e) 'Home from Hospital' support service. This team will act as a stronger "pull" in the system to			

		safely discharge people and support their return home. f) Increase community nursing capacity to enable more people to choose to received End of Life care at home			
	Frequent flyers – a multi-agency approach	'Frequent flyers' - a more formalised/ co-ordinated approach with a care plan which could be accessed which gives the relevant information and directs the doctor/clinician seeing the patient to the right actions. This will also need to include access to the GP and relevant integrated neighbourhood team that have experience with that patient.			
	Ambulance services	Exploring other opportunities with YAS			
	Information technology and enablers	There are a range of IT initiatives in the city focused on improving communication and access to information for clinical teams – especially those in primary and community care. Undertake a clinical audit of a sample of patients who have been admitted to hospital. The audit will ask the question "what could have been in place in the community to prevent this admission in future?" The audit results will then be used to inform more detailed, precise plans in 15/16. Workforce planning			
		TOTAL	11,867		