Supplementary Information
Leeds Better Care Fund

Introduction

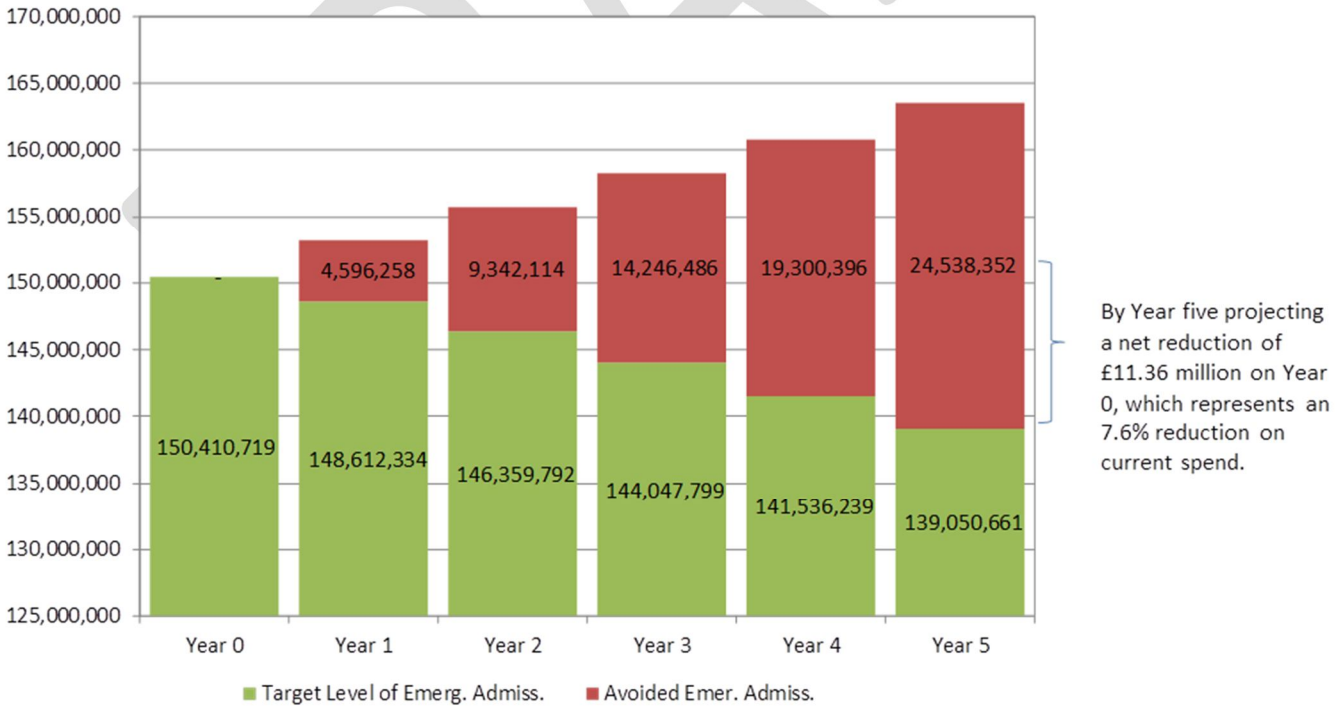
The total value of the Leeds Better Care Fund (BCF) is in excess of £55million. It is a fund of a size that can make a real different to patients and the people of this city and we are determined that this money makes a difference. The concept of the Leeds £ (a common currency that runs through all of health and social care services in the city – see appendix) is already well established, and the establishment of the BCF signals that this is now being brought into reality.

It is important to be clear – the BCF is not new money. Over recent years, the city has already moved many of its core health and social care services into a jointly commissioned environment. The range of jointly commissioned services has recently been expanded to include the Leeds Equipment Service. The BCF therefore, offers an opportunity to bring in new governance arrangements around this existing portfolio of jointly commissioned services and commission more services jointly.

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

Calculating the return on investment from the BCF

The city has set itself a target of a reducing the number of emergency admissions to hospital by 15% over the next five years, against a backdrop of increasing demographic growth and therefore demand. This is set out in the chart below.



If the city were to continue on its current trajectory and factoring continued increases in demand, in five years time the city would be spending over £163million on emergency admissions. It is on this figure that a reduction of 15% has been modelled. If successful the city will save £24millon on where

it should be, which is equivalent to an £11.4million real terms reduction in spending. Investments from the BCF will support the delivery of these savings.

For the purposes of the BCF, these saving reductions have not been apportioned to individual schemes. It is not possible to be definite about the individual contribution of each scheme. Therefore, the projected saving target of £24million has been divided out among all schemes.

Pre-committed spend
Some of the funding listed in the tables below has already been allocated to initiatives prior to the BCF coming into effect. All of these pre-committed schemes are all focused around reducing avoidable hospital and care home admissions, reducing re-admissions and facilitating discharge.

2014/15 – The Shadow Year for the Better Care Fund
The BCF doesn't actually come in reality until 2015/16. 2014/15 is a shadow year for the fund. Therefore the funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year. The figures in this document represent the CCG and local authority allocations for this work next year, and the likely minimum values that will be allocated to these same schemes in 2015/16 that will go into the live BCF.

2014/15 also represents a shadow year for testing the governance arrangements for the BCF in Leeds. As set out in the main document, the fund will be overseen by the Integrated Commissioning Executive (ICE) who will be held accountable for it delivering on its aims and objectives by the Health and Wellbeing board

How the fund has been divided
In order to manage the fund we have made the decision to sub-divide the fund into a schemes that support already well established joint commissioned and/or jointly provided services, and new schemes that provide further "invest to save" opportunities. Some of this funding is recurrent and some is non-recurrent. Schemes of recurrent and non-recurrent funding have been separated below into two tables.

Table 1. Recurrently funded schemes

Scheme No.	Name	Description	Investment 2014/15	Investment 2015/16	Return	
			£000	£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.		5,300		
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.		2,059		
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.		4,609		
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	Currently community matron services in the city are funded by CCGs and are part of the		2,683		

	matrons	integrated neighbourhood teams. By moving this funding to the BCF will support the continued integration of this service into our integrated health and social care model				
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. This will be in the range of £11.9m to £12.5m, awaiting clarification.		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 - Care Bill*	*This is to support the IT requirements of the Care Bill.*		*744*		
	Revenue	TOTAL		39,071		
	Capital	*TOTAL*		*744*		

Table 2. Pump Priming – Invest to Save Schemes

Scheme No.	Name	Description	Investment 2014/15	Investment 2015/16	Return	
			£000	£000	£000	£000
11	*Social care capital grant - Transformation*	*This is to fund capital and infrastructure projects across the city that support the integration agenda and have a benefit for both health and social care.*		*1,100*		
12	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. Additional schemes may include the provision of enhanced support to Care Homes and the housebound through GP visits and use of teleconferencing/telehealth/telemedicine facilities.		2,141		
13	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. The role will also have a key coordination role with primary care, supporting memory clinics in GP surgeries across each of the neighbourhoods.		400		

14	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. Adherence to proscribed treatment to maximise clinical effectiveness and health benefit. This would likely be provided through increasing capacity of existing community nursing teams.		TBC		
15	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.		50		
16	Expand community intermediate care 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 and to expand the community bed bureau to 7 days working. This scheme will also incorporate funding for additional capacity for nurse-led End of Life Care beds.		£180K Staff £406K Beds £50K Bureau £500k EoL **Total £1,136K**		
17	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) Fund additional discharge facilitation roles d) Extend the home care service to support 24/7 support for service users e) Enhance Community Matron Service to provide proactive care management. This service will complement the primary care schemes in reducing admission, readmission and 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 End of Life Care at home, have increased weekend capacity and support earlier discharge		LCES - £130K EDAT_£300K Dis F - £210K HC -???? tbc CM - £1500k DN's – TBC **Total £2,140k + TBC**		
18	Frequent flyers – a multi-agency	The top five frequent attendees at LTHT A&E account for over 500 presentations per month. These individuals often have complex health and social care needs and need to be tackled with		50		

	approach	a more coordinated approach to their care. This scheme aims to provide 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.				
19	Ambulance services	Exploring other opportunities with YAS to reduce duplication and improve efficiency. Examples of this include near patient testing, minor injury/illness management and easy access to rapid-response social & community care services.		TBC		
20	Information technology	There are a range of IT initiatives in the city. These are focussed on the following areas: a) Improving communication and access to information for clinical teams working in different organisations b) Improving data quality and information to use when making commissioning decisions c) Embedding the NHS number as the only person/patient identifier across health and social care in the city		1,800		
21	Care Bill	Revenue implications of care bill introduction. National £135m, local would be circa £2m revenue but not ring fenced. Scheme to be developed.		TBC		
22	Improved system intelligence	In addition, this fund will be used to 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 commissioning plans in 15/16.		80		
23	Workforce planning & development	The city has a clear and stated aim to move activity and demand away from urgent and emergency care into the community. As patients move to different places in the system, staff will need to move with them. The city needs to have a focussed recruitment, retention and re-training strategy in place, so that staff can be deployed in city where they are needed most.		50		
	Remaining Funding	14/15 – to fund pump priming of schemes so that they can commence prior to April 2015. 15/16 - Balance remaining to support "TBC" and contingency	2,759	6,161		
	Pump Prime Total Revenue			**14,008**		
	Pump Prime Total Capital			***1,100***		

Table 3. Grand Totals of BCF

Scheme No.	Name	Description	Investment 2014/15	Investment 2015/16	Return	
			£000	£000	£000	£000
	Grand Total Revenue		**2,759**	**53,079**		
	Grand Total Capital			***1,844***		

Measurement and metrics

National Measure 1: Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population

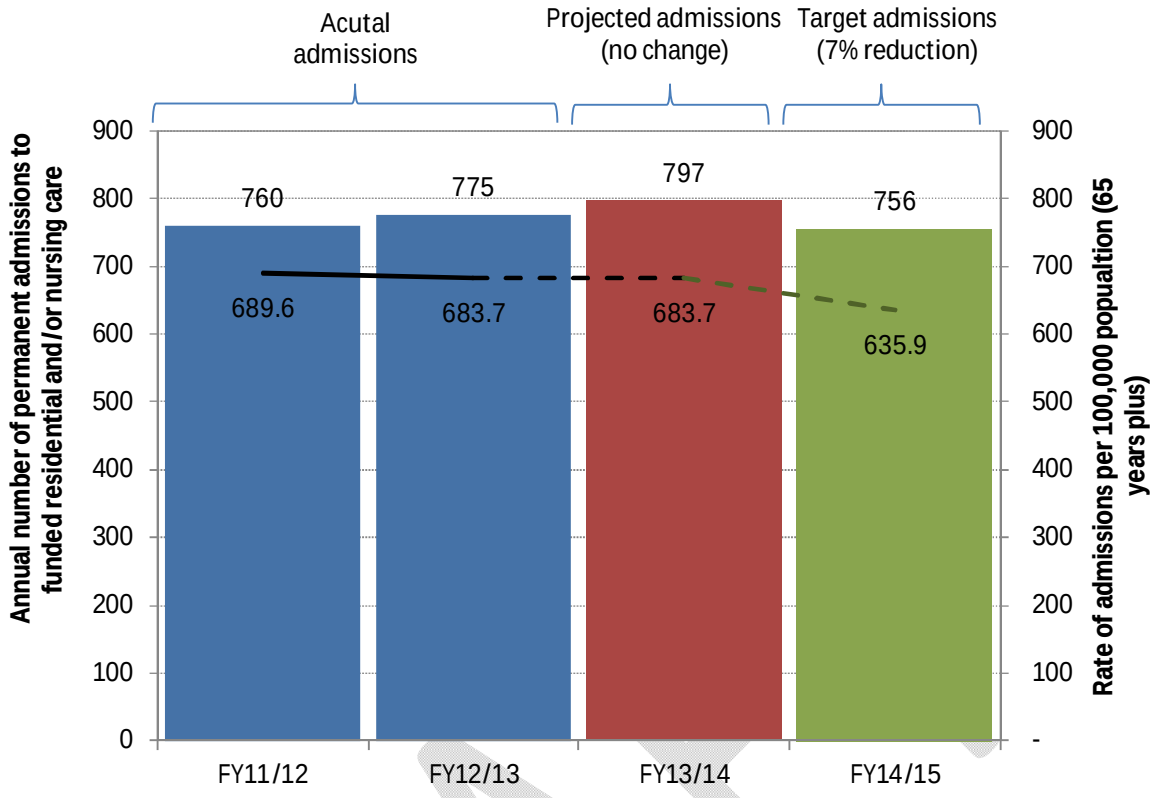
The chart below presents the historic data that is currently available, together with a projected figure for FY13/14 (assuming admission rates remain flat) and a proposed target admission rate for FY14/15 (which represents a gross reduction of **7% on projected demand**, and a **3.6% reduction on FY12/13 admissions**). This level of ambition has been arrived at with consideration to the following factors:

1) ONS population projections point to continued growth in Leeds's 65 plus population (by between 2 and 2.8% per year for the next few years reaching **118,827** by Mid-2015)
   - Therefore, to maintain performance at current levels, the actual number of permanent admissions to residential and/or nursing homes will need to increase accordingly

2) When benchmarked against the 'core cities' Leeds has the lowest admission rate of all of the core cities, and 11 of our 15 comparator local authorities had higher figures than Leeds in FY12/13
   - This suggests Leeds as a care economy is already performing well on this measure, and the future scope for improvement is constrained by our previous good performance and the relative needs of Leeds citizens.

3) Not all admissions to residential and nursing care are undesirable, and a balance needs to be met between ensuring individuals are offered support to live independent lives in the community whist recognising some will benefit from being cared for in a care home

4) Restricting residential and nursing home provision for people with genuine needs risks negative outcomes in relation to unplanned admission to hospital and excessive home care costs. For this reason Leeds is proposing using total bed days in residential and nursing placements as an additional performance measure which is considered more sensitive to inappropriate admissions.



National Measure 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

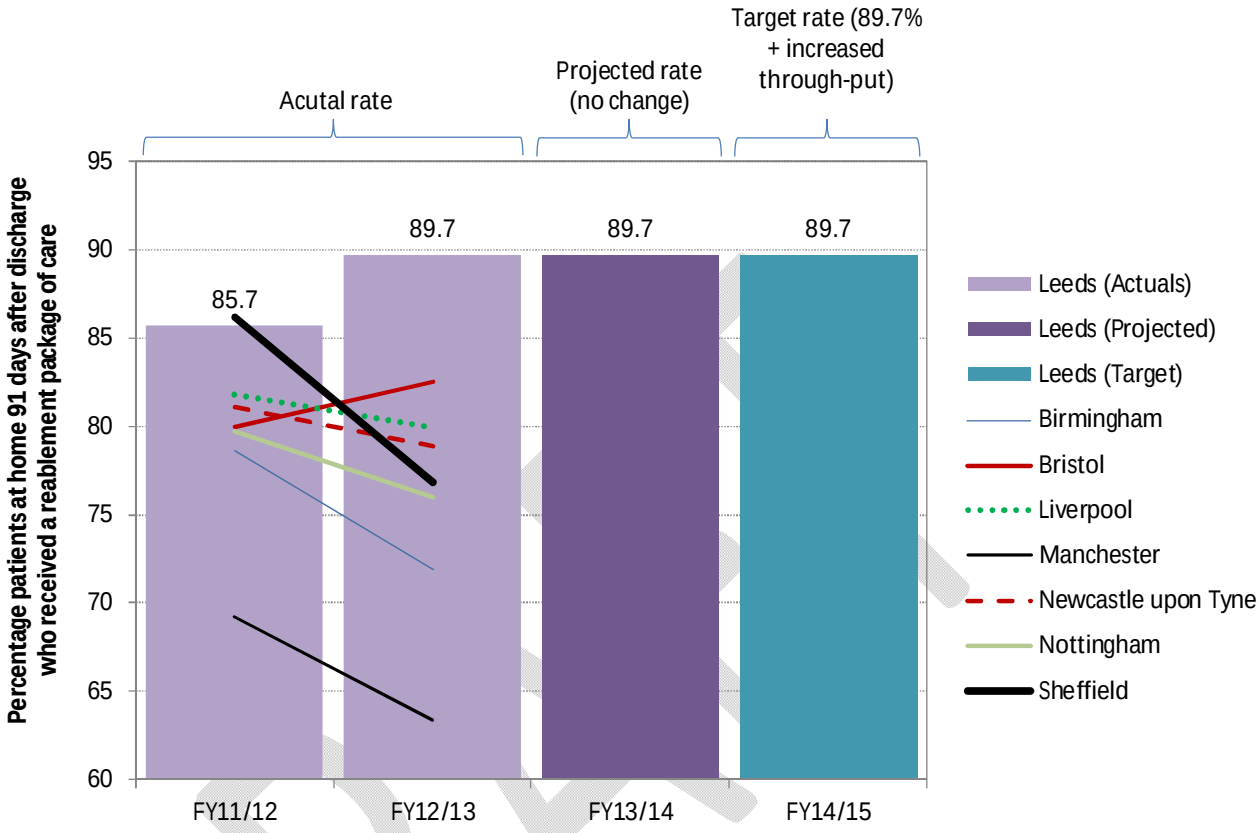
The chart below presents the historic data that is currently available, together with a projected figure of 89.7% FY14/15 (assuming **current performance is maintained** whilst increasing the numbers of patients being managed through the reablement service by 440%). This level of ambition has been arrived at with consideration to the following factors:

5) Performance improved between FY11/12 and FY12/13, with 89.7% of patients who received a reablement package remaining at home 91 days after discharge from hospital for FY12/13 (based on the sample used).

6) When benchmarked against the 'core cities' Leeds has the highest rate of all of the core cities and Leeds already performs in the top quartile both nationally and among our comparators for this indicator.
   - Whilst this may suggest the reablement service is highly effective, the provision of reablement services in Leeds is low compared to the other core cities, and the 'success' observed in part reflects a marginal affect associated with the limited places being offered to individuals that are most likely to benefit. It is therefore the ambition in Leeds to increase the numbers of people accessing the reablement service to a target of 400 by Q4 FY15/16. This should ensure the reablement service contributes to the wider agenda which is to reduce demand for urgent care services and delay admissions to permanent residential and nursing placements.

7) For Leeds, this performance measure is based on a relatively small sample (70 cases for FY12/13)

- As a consequence monitoring this target will be subject to statistical errors that may obscure any actual change in performance. This 'error' represents a significant risk in terms of how Leeds is held to account on this indicator.



National Measure 3: Delayed transfers of care from hospital per 100,000 population

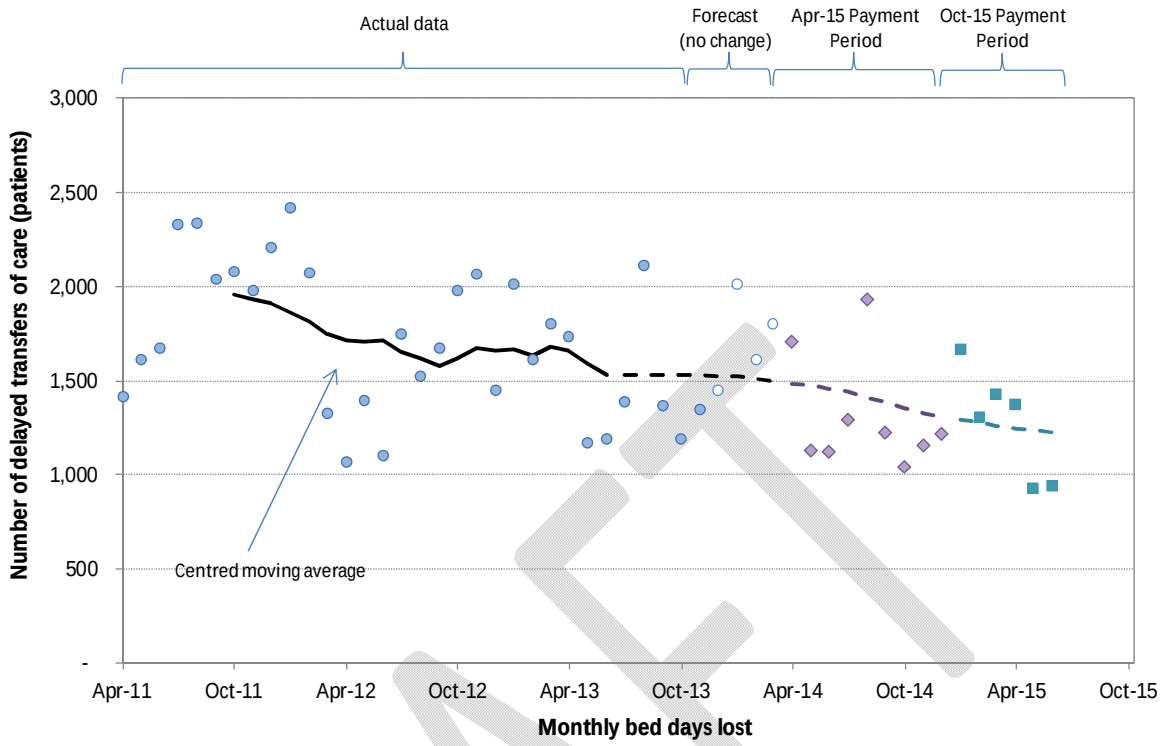
The chart below presents historic delayed transfers of care of Leeds residents (up until Nov-2013) and projects forward future numbers assuming a month-on-month reduction of 1.7% from April 2014 to June 2015 (which equates to a reduction of 20% on present levels or a reducing of 10 occupied beds). This level of ambition has been arrived at with consideration to the following factors:

8) Delayed transfers of care are seasonal, with higher numbers in the winter months
   - This seasonality results in the average for the Jan to Jun-15 period (which is used for the Oct-2015 performance payment) being higher than that for the Apr to Dec-14 period (which is used for the Apr-2-15 performance payment), despite modelling in a month-on-month reduction

9) The long-term trend in delayed transfers of care has remained relatively flat since Apr-2012
   - This supports setting a flat baseline going forward (assuming no impact)

10) When benchmarked against the 'core cities' Leeds is middle of the pack
   - If the city performed at the same level as Newcastle (the best performing core city) numbers of delayed transfers would fall by 12%

Total bed days lost to delayed transfers of care for Leeds residents



National Measure 4: Avoidable emergency admissions

The chart below presents historic numbers of 'avoidable' emergency admissions by month (up until Nov-2013) and projects uture numbers assuming a **month-on-month reduction of 0.85%** from April 2014 to March 2015 (which equates to a real terms reduction of **10% on the baseline position**). This level of ambition has been arrived at with consideration to the following factors:

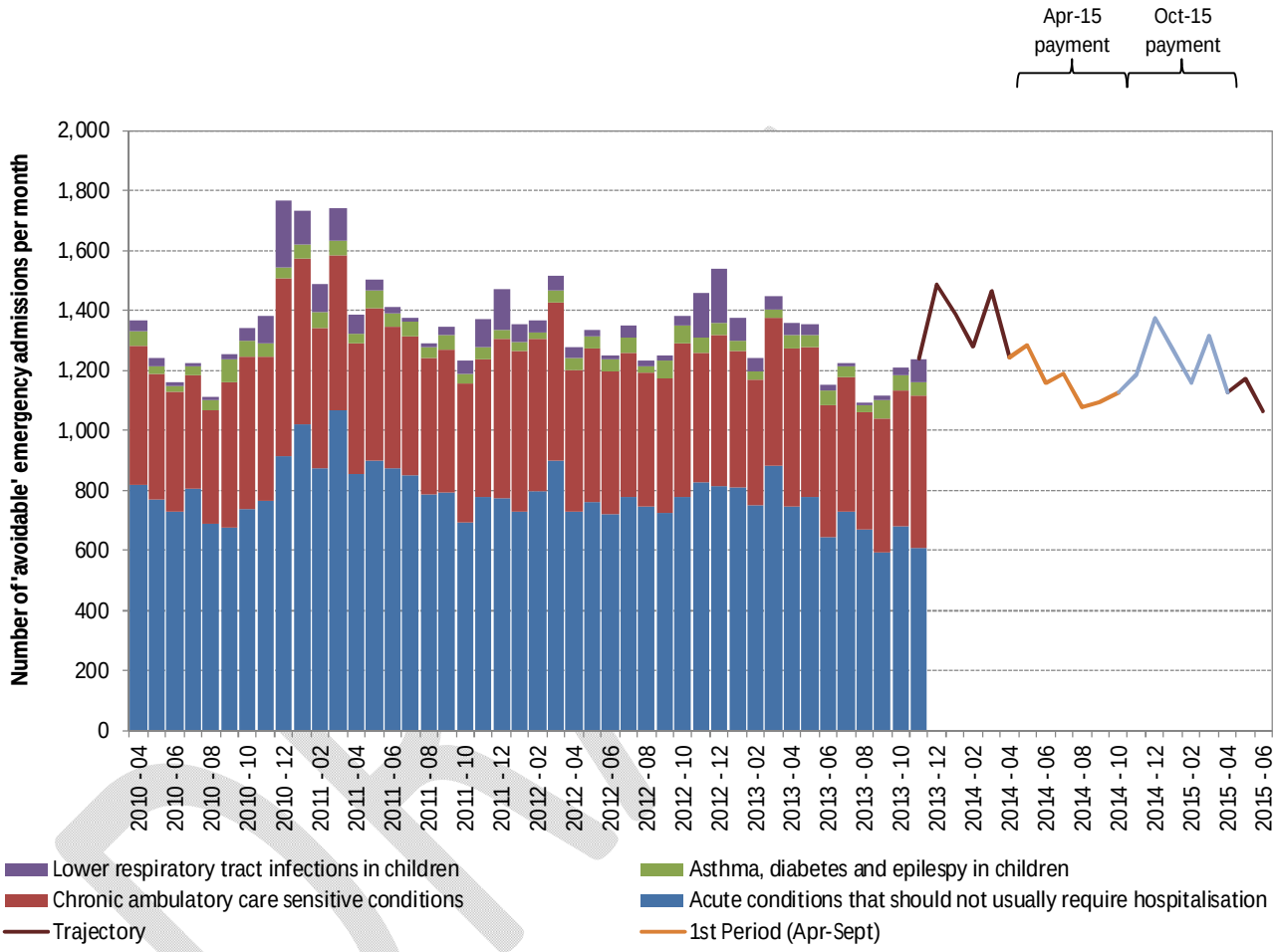
11) Despite a growing population, Leeds has seen a downward trend in 'avoidable' emergency admissions, which is consistent with a reduction in all emergency admissions over the last couple of years
    - This trend can be attributed to changes in the urgent care pathway where patients who would previously have been admitted to an inpatient ward are held in assessment areas prior to discharge. As this pathway redesign is now complete, the baseline has been set using activity for Oct-12 to Sep-13.

12) When benchmarked against the 'core cities' Leeds has the third lowest rate of all of the core cities and is close to the national average
    - This suggests scope for improvement, although as a consequence of local variations in coding practices on how assessment pathways are recorded, care must be taken when interpreting these findings.

13) 'Avoidable' emergency admissions are seasonal, with higher numbers in the winter months

- This seasonality results in the average for the Oct-14 to Mar-15 period (which is used for the Oct-2015 performance payment) being higher than that for the Apr-15 to Sep-14 period (which is used for the Apr-15 performance payment), despite modelling in a month-on-month reduction

14) The 10% reduction on baseline exceeds the level of statistically significant of 2% as derived using the 'Better Care Fund – statistical significance calculator' and is in line with the cities aspiration to reduce emergency admissions rate for the city by a minimum of 15% by FY18/19.



National Measure 5: Patient/service user experience

This measure is under construction by NHS England and until this information is available Leeds is unable to set its level of ambition for this measure.

Local Metric: Estimated diagnosis rate for people with dementia

Leeds has selected the estimated diagnosis rate for people with dementia (which is within the NHS Outcomes Framework) as its local metric for the Better Care Fund. This section is based on the city's commitment to improve the lives of people with dementia in Leeds, which to a large part will be delivered by seamlessly managing these individuals' needs across the health and social care system.

For reporting purposes, NHS England's Dementia Prevalence Calculator (www.primarycare.nhs.uk) has been used as the data source for the 2013 baseline data. The future prevalence of dementia in the population has been estimated by increasing the 2013 baseline figure by 2.3% annually (which

reflect the projected growth rate of the elderly population based on the ONS 2011 Subnational Population Projections).

An improvement trajectory has been set to achieve the national ambition of having two thirds of all dementia patients on GP Practice dementia registers by March 2015 (see chart below). This trajectory accounts for the phased introduction of new services to help identify (and diagnose) individuals with dementia.