Updated June 2014

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1. PLAN DETAILS

a) Summary of Plan

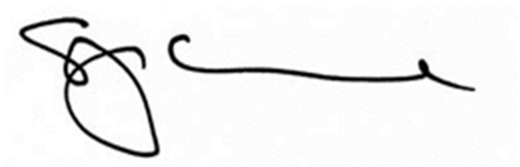
Local Authority	**Leeds City Council**
Clinical Commissioning Groups	**NHS Leeds South and East CCG**
	NHS Leeds West CCG
	NHS Leeds North CCG
Boundary Differences	**None. 3 x CCGs are jointly coterminous with local authority**
Date agreed at Health and Well-Being Board:	**09/07/2014- agreement by email Board meeting on 16/07/2014**
Date submitted:	**09/07/2014**
Minimum required value of ITF pooled budget: 2014/15	**NIL**
2015/16	**£54.9m**
Total agreed value of pooled budget: 2014/15	**£7.759k**
2015/16	**£54.9m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Leeds South and East CCG
By	 Matt Ward
Position	Chief Operating Officer
Date	**09/07/2014**

Signed on behalf of the Clinical Commissioning Group	Leeds North CCG
By	 Nigel Gray
Position	Chief Officer
Date	**09/07/2014**

Signed on behalf of the Clinical Commissioning Group	Leeds West CCG
By	 Philomena Corrigan
Position	Chief Officer
Date	**09/07/2014**

Signed on behalf of the Council	Leeds City Council
By	 Sandie Keene
Position	Director of Adult Social Services
Date	**09/07/2014**

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	**09/07/2014**

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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. These boards have developed the schemes outlined in Leeds' BCF through the "supplementary information" part of the submission:

- Integrated health & social care board
- Urgent care board
- Informatics board
- Palliative care strategy group
- Dementia board

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 February, 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
- Consultation event with over 25 members of Healthy Lives Leeds, the 3rd sector representative collaborative.

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.

This excellent track record of working together across the health and care economy has resulted in the city being selected as one of 15 national Integration Pioneers. For more information on our work to date, please see www.leeds.gov.uk/transform

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

BCF engagement

Following on from the submission of the first draft of the BCF, HealthWatch Leeds has led a rapid consultation with the public, using both face-to-face and social media approaches, to test out and support further development of proposals. The results of this consultation tell us that, overall, the proposals set out for Leeds' Better Care Fund were supported. A number of proposals particularly resonated, including Eldercare Facilitators, Enhancing Integrated Neighbourhood Teams and reducing emergency admissions through a case management approach to urgent care. Other findings on the proposed schemes will be used to inform development work going forwards. The full findings are attached at Appendix 6.

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

Ongoing engagement

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

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

Our Charter for Involvement in Integration was co-produced with people who access services and their carers, includes a clear expectation that the views of people who use services will be integral to the reshaping of those services, and we are committed to providing feedback on how those views have been incorporated into our plans. In line with the Charter, patients and service users are already involved in designing services and shaping change through patient advisory and liaison groups and representation on boards and steering groups. Additionally, staff groups across health and social care have also been involved from the beginning in the development and implementation of our plans for integrated services. The Integrated Teams are also using a Leeds University developed service feedback process whereby trained volunteers interview patients and their comments are then used to inform future service improvements.

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

e) Related documentation

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

Document or information title	Synopsis and links
Appendix 1 - Charter for involvement	
Appendix 2 - Leeds integrated health and social care pioneer bid	
Appendix 3 – Leeds £ plan on a page	
Appendix 4 - Leeds Integrated Health & Social Care Outcomes Framework	
Appendix 5 – Integration dashboard	
Appendix 6 – results of HealthWatch Leeds public consultation on Leeds' BCF	
Appendix 7 – Best City approach to health and social care – executive summary	
Appendix 8 – Case study: Patricia's story	
Appendix 9 – 5 year strategy plan on a page	

2. VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- Drawing on your JSNA, JHWS and patient and service user feedback, where are health and social care services most in need of integration in your local area?
- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

As a Pioneer, Leeds strives to be the Best City for Health and Wellbeing in the UK. Our vision is that Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest. As part of becoming the Best City, commissioners and providers have a shared ambition to create a sustainable, high quality health and social care system. How we will work together is set out in appendix 7.

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

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

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

JSNA and JHWBS

The Leeds Joint Strategic Needs Assessment was published in 2012, and formed the basis on which the city came together to agree its Joint Health and Wellbeing Strategy in 2013. The story told by the JSNA around integration of health and care concerns the conditions and populations most likely to be affected by services delivered by multiple teams and organisations: people with Long Term Conditions (LTCs), people with

complex needs, and people over 75.

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

- Dementia and co-morbidity - In line with national trends, dementia prevalence is rising in Leeds, and while 'as a primary diagnosis it features in a relatively low number of acute hospital admissions, it is thought to be a significant factor in admissions for other conditions … It has been estimated that 40% of people aged 65 or over in acute hospitals at any one time (or 25% of all people in hospital) have dementia.' The JSNA notes that 'analysis of adult social care data indicates that people in less deprived areas, who are more likely to be self-funding for social care, are the lowest users of services. Therefore there may be gaps in access to important information, advice and assessment services for older people with age-related dementias'. Accordingly, dementia is a focus within our transformation programme and BCF.

- Hospital admissions for hip fracture - Three-year average rates of hospital admission for hip fracture among residents in Deprived Leeds are significantly higher than Leeds overall, while rates for females are significantly higher than for males. The JSNA notes that 'fall prevention programmes can be effective in reducing the number of people who fall and the rate of falls. Targeted strategies aimed at behavioural change and risk modification for those living in the community appear to be most promising. Intervention programmes that include risk factor assessment and screening have been shown to be effective.' Again, this has been built into our BCF.

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

- 'We need to move towards the holistic management of people with long term conditions, focusing on the individual and their mental as well as physical needs, rather than on specific disease pathways:
- Co-production and self-care as overall principle running throughout the whole approach;
- Long term conditions including dementia will become more widespread as the population ages, as will the number of older people caring for a spouse or other family or friend with these needs;
- In the future, outputs from the risk stratification tool used in primary care will give us more data about those living with more than one long term condition.'

A new JSNA for Leeds is currently being written, planned to be an ongoing, live and responsive assessment of need for the city. Future plans for the JSNA relevant to integration efforts include better understanding of comorbidities, the distribution of LTCs, more patient voice, an emphasis on the delivery of services in relation to patient experience of multiple teams/organisations, and the inclusion of many of the Better Care Fund metrics.

The Joint Health and Wellbeing Strategy

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

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

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

Leeds' Transformation Programme and 5 Year Strategy

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

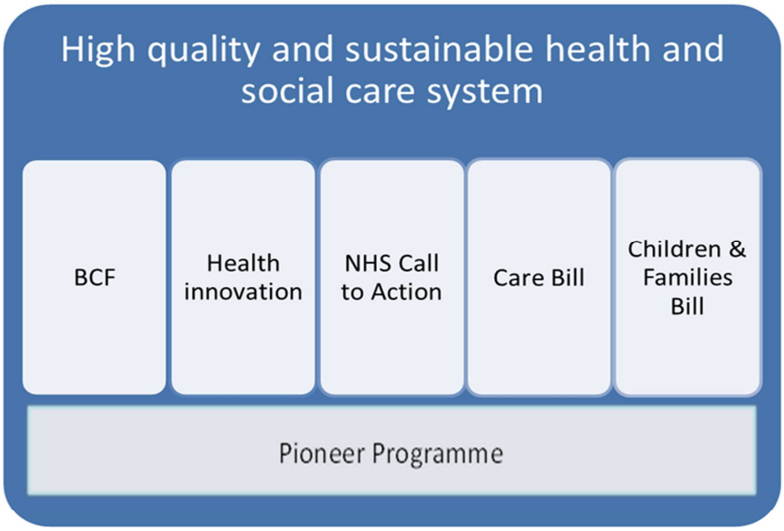
- Bring the overall cost of health and social care in Leeds within affordability limits - transformation is required to reduce current costs.
- Change the shape of health provision so that care is provided in the most appropriate setting.

The BCF is a component part of this programme, and we recognise the BCF alone will not have the scale of impact required. As a first step, the Transformation Board has overseen the development of the 5 Year Health Commissioning Plan (Plan on a page is set out at appendix 9), agreed by the Health & Wellbeing Board at its meeting of 18th June 2014. Work on the city-wide strategy will now continue to incorporate the social care, public health, workforce, estates, informatics, infrastructure and provider perspectives in more detail and further refine the economic modelling and measurement processes.

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

Vision for integrated health and care services

For the past two years, the health and social care community in Leeds has been working collectively towards creating an integrated system of care that seeks to wrap care and support around the needs of the individual, their family and carers and helps to deliver on our wider vision. The model below sets out how the BCF fits into this, alongside other key strategic drivers and making best use of the freedoms and flexibilities of the Pioneer programme.



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

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

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

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

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

Self-care and self-management (supported by Leeds' ambition to be a digital city for

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

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

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

Integrated Health and Social Care Teams, covering the whole city, are a key element to wrapping care around the needs of people, their families and their carers. These teams will continue to be developed and enhanced over the next five years to better deliver care closer to home, and are increasingly improving coordination of activity between all health and social care partners.

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

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

Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The Leeds approach to developing our BCF

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

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

2014/15 will be used as a shadow year to "pump prime" the Better Care Fund proposals, to help ensure that the city will benefit from and be able to maximise the opportunities from the BCF as soon as possible, in line with both its aspirations and Pioneer status to go further, faster. As the BCF does not come into being until 2015/16, 2014/15 the funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year. The figures set out in our template represent CCG and local authority allocations for this work next year to work up and test out the "invest to save" opportunities, and the likely minimum values that will be allocated to these same schemes in 2015/16 that will go into the live BCF.

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

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

Aims
As an Integration Pioneer, we will be aiming:

- To be recognised as a national and international centre of health and social care excellence

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

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

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

Objectives

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

Our BCF objectives are:

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

What we will measure

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

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

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

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

How we will measure

There are positive signs from the Leeds Integrated Health & Social Care Outcome Framework (Appendix 4) that suggest progress can be measured, and we continue to

evaluate progress using this tool within Leeds. Additionally, effectiveness of integration has been embedded into city wide analysis through the use of a dashboard approach (Appendix 5). We will continue to use this as part of the BCF monitoring system. In addition to this, we will monitor:

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

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

b) Description of planned changes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (annex 1) for each of these schemes. (Any individual contract worth at least 5% of the BCF total should be listed as an individual scheme. A number of small contracts may be grouped together thematically provided the total value is less than 10% of the BCF total.)

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

c) Impact on patients/service users' experience
With reference to specific services referred above, please describe how the plan will change an individual patient or service user's experience of health and social care services in:

- April 2016
- Five years

Our BCF is geared towards contributing to a high quality and sustainable health and social care system, through the broader Transformation Programme. In particular, the schemes will support the work programme "Effective admission and discharge" - Integrated management of patients to reduce dependence on secondary care beds. Programme will focus on; preventing admission from A&E, early supported discharge, appropriate discharge and prevention of re-admissions. These objectives should result in a better experience for people of Leeds underpinned by the following key principles: the appropriate level of care provided closer to home, a focus on self management, joined-up care across multiple providers, urgent care should become planned care as far as possible, we must use the latest technology to enable patients to be seen by the right professional at the right time in the right place and involvement of patients and service users is crucial to meeting the challenge.

With particular regard to Leeds' vision for integrated health and social care and impact on service users, this is based on what local people tell us they want: "Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect".

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

In developing this vision, we identified a common narrative through development of 'I statements' and design principles for integration enables us to identify 'how we will know when we get there'. Using the needs and wants of people accessing services and their carers to form the principles behind our definition of integrated care helps us to ensure that we make changes that can improve outcomes and experiences for people accessing services, through keeping the voice of the citizen at the heart of everything we do. Our outcomes framework (appendix 4) gives further detail. However, we are working to ensure that the answer is "yes" to following questions over the next five years. A recent evaluation of our integrated care teams tell us we are already making good progress.

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

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

Both our recurrent and invest-to-save BCF schemes will directly impact on making the conditions outlined above the norm. For example, "enhancing integrated neighbourhood teams" and 3rd sector provision will enable best use of community services and support. Working on urgent care, reablement and community beds will mean the right people are seen in hospital and can be supported to move into a community / home setting as soon as safe and appropriate. Working to improve our information technology offer will smooth out data flows and enable staff to work together more effectively to access service user data.

Leeds has also been capturing service user / patient stories as per the below. In line with findings from the HeathWatch consultation, it is clear the three objectives of the BCF (Reducing the need for people to go into hospital or residential care; Helping people to leave hospital quickly; Supporting people to stay out of hospital or residential care) resonate.

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

- 'My doctor says they're trying to help people like me avoid having to go into hospital if they don't need to. That's good. I find hospitals very stressful!' - Patricia, 78, Gledhow (Patricia's full story can be found in Appendix 8).

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

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers, and include:

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

The Leeds health and social care economy is facing a financial challenge of over £100m a year. Leeds Teaching Hospitals NHS Trust is looking at around a £280m deficit over the next 5 years; 2015/16 is the year presenting the biggest challenge. Savings need to be identified not only to plug this gap, but also to free up monies to allow investment in more joined up community based services.

A reduction in emergency acute activity is the main driver for commissioners in Leeds to generate savings for both the health and social care commissioners and provider in the city. Leeds Teaching Hospitals NHS Trust recently consulted on its 5 year strategy and organisations in the city contributed to the consultation, linking it back to the content of BCF plans. LTHT, in its emerging strategy, has stated its intention to deliver seamless integrated care across organisation boundaries, with a reduction in urgent admissions for frail elderly patients and those with long term conditions by 20%. In order to realise these savings, there is a need to also invest in preventative measures through better integrated working and more joined up care in the community.

Realising savings through reductions in hospital activity is a big risk for the city - the most obvious implication is that the NHS in the city becomes financially unsustainable and service delivery targets fail to be met. The targets most at risk include:

- Failure to meet the RTT 18 weeks elective care target – due to increased pressure on beds from acute admissions
- Failure to meet the A&E 4 hour waiting time target

Increasing community capacity should act not only to promote the integration agenda, but also to support the delivery of these key performance targets.

Changes in finance and commissioning arrangements are also key to generating savings. Leeds is a Year of Care pilot and recent work, carried out by the Year of Care tariff working group, has looked to identify patients who have remained in hospital beyond the point at which they were medically fit for discharge. The work found that over a third of patients were staying in hospital beds longer than was clinically necessary, but these patients attract the same tariff as a patient who goes home earlier. Commissioners in Leeds are looking at more intelligent commissioning and contracting models that will incentivise timely discharge, and tariff arrangements that reflect the actual cost as well as the amount of time someone stays in hospital - thus potentially generating further savings for the Leeds pound.

Health and social care commissioners in the city are also mindful that hospital-based care must be sustainable. Given the scale of specialised activity at Leeds Teaching Hospital it is imperative the development of the acute strategy for Leeds is cognisant of the approach of NHS England to specialised services commissioning. It is crucial that as less money and activity is delivered in the acute sector as a result of the BCF initiatives, costs in that sector either reduce or are refocused on specialist activity. Therefore, it is essential to develop a citywide plan which factors in the commissioning intentions for specialised services, working closely with NHS England and the local area team under the auspices of the Health and Wellbeing Board. Savings in the health and social care sector need to be generated by shifting activity into the community, and making the entire sector more focussed on prevention.

The hospital itself also needs to become more efficient to ensure that it remains sustainable. Leeds Teaching Hospital NHS Trust's goal is financial stability, with a recognition that efficiency savings of 20-25% must be made over the next three years. This will be achieved through: treating patients differently who do not need to be in hospital reducing length of stay, purchasing and the innovative use of information technology.
At the same time, we need to ensure that acute services in Leeds continue to provide excellent patient care, develop an effective and caring workforce and lead on research,

innovation and education. It is also important to ensure that any internal efficiency programmes in Leeds Teaching Hospitals have direct links with the Transformation Board programmes and in turn the BCF plans.

As a consequence of moving to a more prevention focussed agenda, there are implications for the workforce size and skill mix and thus workforce redesign is a priority. Modelling need and developing a future workforce strategy with provider organisations to support the shift in skill base from acute to community care for Leeds is one of our proposals within the BCF plan and will be supported through the Pioneer programme, working with Health Education England and Skills for Care to shape this. As non-elective activity starts to reduce, and community activity rises, re-training the workforce will become increasingly important and workforce development to meet changing needs is part of our wider transformation programme. Roles that were once only available in the hospital will still be required, but in a different setting.

In the longer term, the BCF workforce development scheme will focus on strategy implementation, e.g. training to ensure we have the correctly qualified staff working in the right places and with the right patients to create the integrated health and social care system patients, service users and their families deserve.

Note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template contained in annex 2.

e) Governance

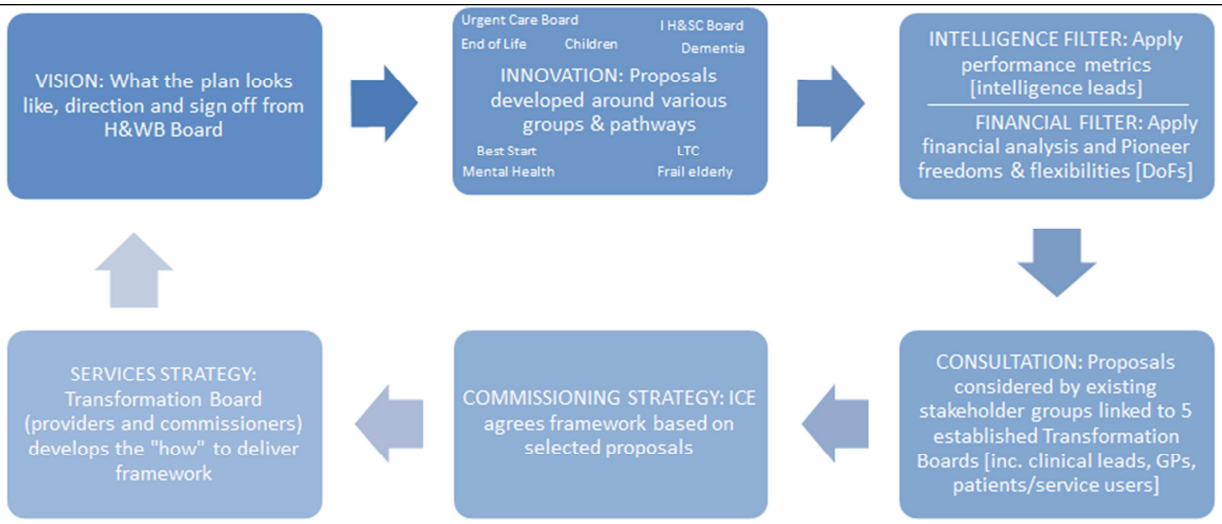
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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

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

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

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



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

3. NATIONAL CONDITIONS

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

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

Protecting social care services in Leeds means ensuring that those with eligible needs within our local communities continue to receive support, despite growing demand and budgetary pressures.

This means:

- **Supporting people to live independently and well**
- **Releasing pressure on our acute and social services**
- **Investing in high-quality, joined-up care in and around the home**

At a time when we are planning to make significant investments in community-based, person-centred health and care services, we are seeing rising demand on our health and care services as a result of changing demography and as we get better at keeping people alive longer. Against this backdrop, local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.

Our BCF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and social care system as a whole. We recognize that the BCF alone will not

resolve the challenges faced by Social Care, but we are confident that as part of the overarching transformation plans in the city, these will be met.

Our primary focus is on continuing to develop new forms of joined up care which help to ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and social care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services.

This is illustrated by Adult Social Care's 'Better Lives for People in Leeds' strategy – our commitment to supporting people to live independently and giving them more say in how they live their lives. Our ambition is to make Leeds a place where people can be supported to have better lives than they have now. Over the next five years, we intend to continue our achievement towards this through a mixture of enterprise and integration, where the council join up with health and other service providers to create an adult social care sector that is varied, accessible to all and fit for its purpose. For more information, go to: www.leeds.gov.uk/betterlives

Underlying our vision are the nationally-accepted priorities for social care in the UK, which are:

- Enhancing the quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

Please explain how local social care services will be protected within your plans

Funding currently allocated under the Social Care to Benefit Health grant has sustained the current level of eligibility criteria and ensured the continued provision of timely assessment, care management and review, together with the commissioning of services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. As part of the BCF financial model, the proposal is to sustain and protect the current level of health funding to support social care (£11.9m-£12.5m plus £2.8m reablement) with CCG QIPP programmes used to set up the BCF to develop a recurrent investment fund to transform the social and health care system. This will be the primary mechanism to protect social care services through health spending focusing on reducing demand to services.

As part of the next stage in the development of the BCF health and social care will work together to further develop the programmes of work which will result in additional schemes being developed that benefit the health and social care economy. This may well add further funding to social care to schemes to enable the transformation of the city.

This is required due to the continued financial pressures facing all partners in the BCF. Prior to the consideration of the impact of further Local Authority funding reductions on Social care, Leeds Social Care are facing unidentified CIPs of £7.2m in 15/16. To

maintain essential services at current levels of eligibility, savings generated through the BCF process will be focused on addressing this shortfall as well as the future QIPP challenge facing the NHS. Potentially upwards of an additional £15m contribution to the Councils' wider CIP programme may be required by Social Care in 15/16. Decisions have yet to be made on the level of this contribution to date, however, and further discussions will be required to identify the size of this gap. The focus on the BCF will be to demonstrate a contribution towards mitigating some of these additional pressures through the services developments proposed. However, given the size of the financial challenge faced by Social Care, the challenge will not be met by the BCF alone, but by a commitment of all partners to meet the collective financial challenge for the Health and Social Care economy, of which Social Care is one part, through the established H&SC Transformation programme in the city.

In addition, it is also recognised that, nationally, the BCF includes provision of £185m (£50m of which is capital) for 'a range of new duties that come in from April 2015 as a result of the Care Bill.' Although this funding is not ring fenced, the Leeds BCF includes a draft scheme which could be up to £2.7m non recurrent (£0.7m of which is capital), although further work will be required to quantify the impact of this scheme.

Adult Social Care has a very strong track record of delivering significant efficiencies and has delivered over £70m in the last 5 years to enable ongoing financial challenges to be met, whilst at the same time improving the quality of services to people. These efficiencies have been delivered through a range of measures including the significant decommissioning of in-house services, service redesign and investment in preventative services, together with the implementation of innovative, jointly commissioned and provided social care schemes including the South Leeds Independence Centre, Reablement Service, Integrated Neighbourhood Teams, the Assistive Technology Hub all as part of our ongoing 'Better Lives' programme.

The BCF clearly represents a further opportunity for health and social care to work together to deliver significant savings through more integrated and efficient working, while ensuring that care provided to the people of Leeds remains of the highest standard.

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

Leeds has an excellent track record of supporting carers. Scheme 3 of our plan, "Supporting Carers", dedicates £2,059k to supporting carers of people with dementia, those that have been recently bereaved and respite opportunities (both residential and at home).

In the Care Act, there are provisions for extending carers rights so that they are on par with the cared for. This includes rights to an assessment and entitlement to services. The latest census figures indicate there are 71,600 people who identify themselves as carers. Financial modelling of costs is currently underway which seeks to address the estimated increase in demand and how this will be met. Leeds is working with the ADASS Yorkshire and Humberside regional group to further refine these costs. Our initial estimates provide a range of costs between £5m - £36m for carers' services. The key variable is estimating the numbers of carers that will present for an assessment of their needs and the conversion rate into carers' packages of care. Consequently, it is not possible to specify the level of resource that will be dedicated to carer-specific support through the Care Act.

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

It is not possible at this stage to determine with certainty what the costs and funding implications are for the Care Act (2014). Initial estimates are that that there is an indicative range of up to £46m of costs in 2015/16. The Council is working with partners regionally and nationally to further refine these costs.

Leeds has initiated a programme of work for implementing the Care Act (2014). The Programme consists of several projects which focus on delivering the different aspects of the Act overseen by a Programme Board chaired by the Deputy Director of Adult Social Care. The programme consists of work with a broad range of stakeholders to: understand and model the impact of the Act; the draft guidance and develop options for how the new duties could be met. It has identified the key priority areas as: 1. Carers; 2. assessment and eligibility; 3. IM&T as an enabler; 4. Information and advice.

The option appraisals will identify the most effective and efficient way of meeting the increased assessment and service delivery responsibilities under the Act. This will involve a comprehensive piece of work on demand and capacity planning, particularly as it relates to carers, assessment and eligibility and self-funder.

It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for September. Following this phase of the programme and the options presented, Leeds will take a final decision on how best the new duties will be met.

Alongside this work is a Consultation, Engagement and Communication Strategy to ensure that there is effective engagement with stakeholders including service users.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

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

Leeds already has a 24/7 community nursing and care management service. The BCF offers the city an opportunity to build on this.

A core requirement of the 14/15 contract with all main NHS providers is to work with commissioners to facilitate the delivery of seven day working requirements.

The role out of 7 day services also requires fundamental and large scale change to existing services and we see the BCF targeting seven day working, as set out in the

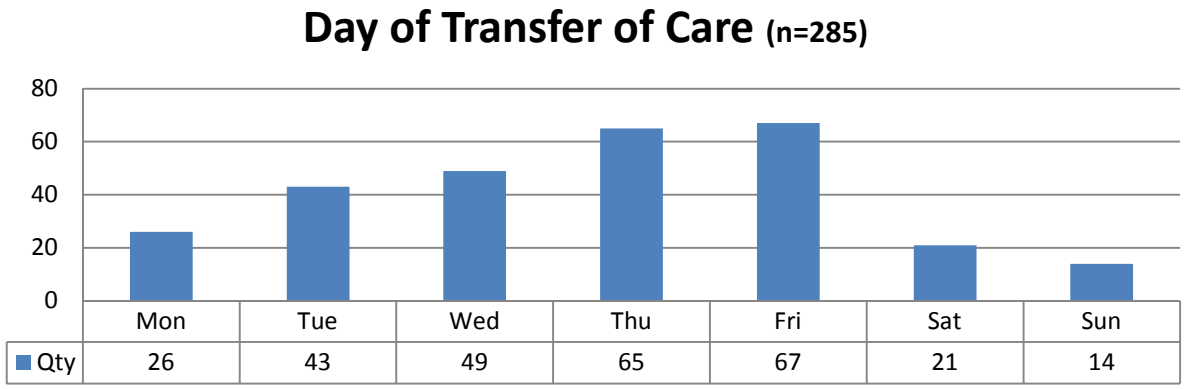
supplementary information section – particularly in relating to the community beds and enhance integrated neighbourhood teams schemes. Operational changes would include:

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

This will allow out of hospital services to better respond to the anticipated increase in transfers of care at weekend from hospitals.

Further work following submission to develop detailed implantation plans for the BCF will involve taking into account the cost of moving to seven day service and equally the potential savings from operating uniformly during the week. Additionally, current CCG contract negotiations with providers are taking account of 7 day working.

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



As a city, our aim is to smooth out this graph by reducing the peaks and troughs seen here throughout the week. Having services available consistently will reduce length of stay and reduce the pressure points on services at certain times of the week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

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

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

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

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

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Within the proposed BCF Informatics scheme is the work required to deliver a strategic solution to obtaining the NHS Number for social care using the national Patient Demographic Service (PDS). The strategic aim is to implement this before April 2015, as part of our work to go "further and faster" towards integration. Alongside this is resource to embed the NHS number in to social care correspondence within that time frame.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

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

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We are committed to ensuring that the appropriate IG controls are in place. All individual health and social care organisations are operating at Level 2 against the IG Toolkit. We are working closely with HSCIC DSCRO to ensure that data flows are in line with Caldicott 2 and have a number of data sharing and data processing agreements in place.

However, there are acknowledged challenges around delivering IG for integrated working, especially shared data, shared systems and common care processes. Therefore, within the proposed BCF Informatics scheme (scheme 19) is the resource required to strengthen the city-wide (multi-organisational) IG expertise.

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

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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

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

To support risk stratification and motive further joint working, a complimentary CQUIN came into effect on April 2014. The CQUIN incentivises Leeds community health services to work in a more interdisciplinary way with primary care, to deliver improved proactive care management. The first quarter has seen close working between all 3 CCG's, their member practices and Leeds Community Healthcare to determine future roles, responsibilities and working practices.

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

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

4. RISKS

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

In the time available for this re-submission of the BCF, Leeds has been unable to provide the financial impact in the risks in the table below and these will be worked on over the coming weeks.

Risk Rank	**There is a risk that:**	**How likely is the risk to materialise?**	**Potential impact** *(if financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Mitigating Actions**
Very high	The savings and efficiencies needed to fund whole system change that meets people's health and social care needs may not be delivered through the work planned.	Probable	Impact across the entire health and social care economy	The proposals within the Better Care Fund submission have been costed and likely efficiencies estimated. There is very little evidence base with few examples of full implementation of schemes. Progress post implementation will be closely monitored but likely impact will be based on a culmination of interventions.
Very high	Hospital beds are not closed as activity drops.	Probable	Beds are not closed and therefore efficiencies cannot be realised. £ Cost per admission…	Leeds Teaching Hospitals Trust plans outline how beds within the acute sector can be closed without destabilising the sector. Impact of specialist commissioning strategy key to understanding overall strategy for LTHT
High	As the NHS is facing 10% real terms budget cut in administration in 2015/16, in addition to the cuts being faced by social care, there will not be appropriate resources available to undertake the necessary work in the schemes.	Possible	The plans cannot be implemented as anticipated and thus do not deliver their expected outcomes.	Resources are being discussed and will be allocated from both health and social care. Governance and monitoring mechanisms will be put in place to oversee the Better Care Fund.
High	Shifting resources to fund new schemes may destabilise current services and	Possible	Destabilise current services and providers, particularly in the acute sector.	Proposals been jointly developed by health and social care organisations across Leeds, including

	providers, particularly in the acute sector.		Structural issues and possible impact on end users.	service providers. This has enabled a holistic consideration of the benefits and dis-benefits of each proposal
High	Work outlined may not adequately ensure the Protection of Adult Social Care services.	Possible	Provision of adult social care services is put at significant risk which could mean that vital services can no longer be provided.	The Protection of Adult Social Care Services has been fundamental to the development of proposals and of Leeds' wider ambition of a high quality and sustainable health and social care system. The focus has been on protecting existing spend whilst developing an investment pool to invest to reduce overall health and social care spend.
High	Operational pressures and the current high volume of business change will restrict the ability of our workforce to deliver the projects needed to make the vision of care outlined a reality.	Possible	Ability of our workforce to deliver the projects needed to make the vision of care outlined a reality. The plans do not deliver their expected outcomes.	Proposals include investment in infrastructure and development to support overall organisational development.
High	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / home care activity by 2015/16.	Possible	Could impact the overall funding available to support care services and future schemes.	Proposals have been developed using a wide range of available data. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed Business Cases and service specifications
Medium	Leeds fails to deliver the outcomes detailed.	Possible	Leeds may suffer reputational damage, especially as there is a public perception that the BCF represents new money and will deliver additional services.	Proposals have been developed through a rigorous process of consultation and engagement, review and scrutiny.
High	The introduction of the Care Bill may result in a significant increase in the cost of care provision from April 2016 that it not currently fully quantifiable.	Probable	Impact on the sustainability of current social care funding and plans.	The Care Bill is a fundamental part of Leeds' work towards achieving the ambition of a high quality and sustainable health and social care system. Specifically, a Chief Officer with specific responsibility for Social Care Reforms has been appointed to plan for the introduction of the Care Bill and monitor its impact.
Medium	Community and social settings may	Possible	Impact on service deliver,	Savings generated through work under the Better Care

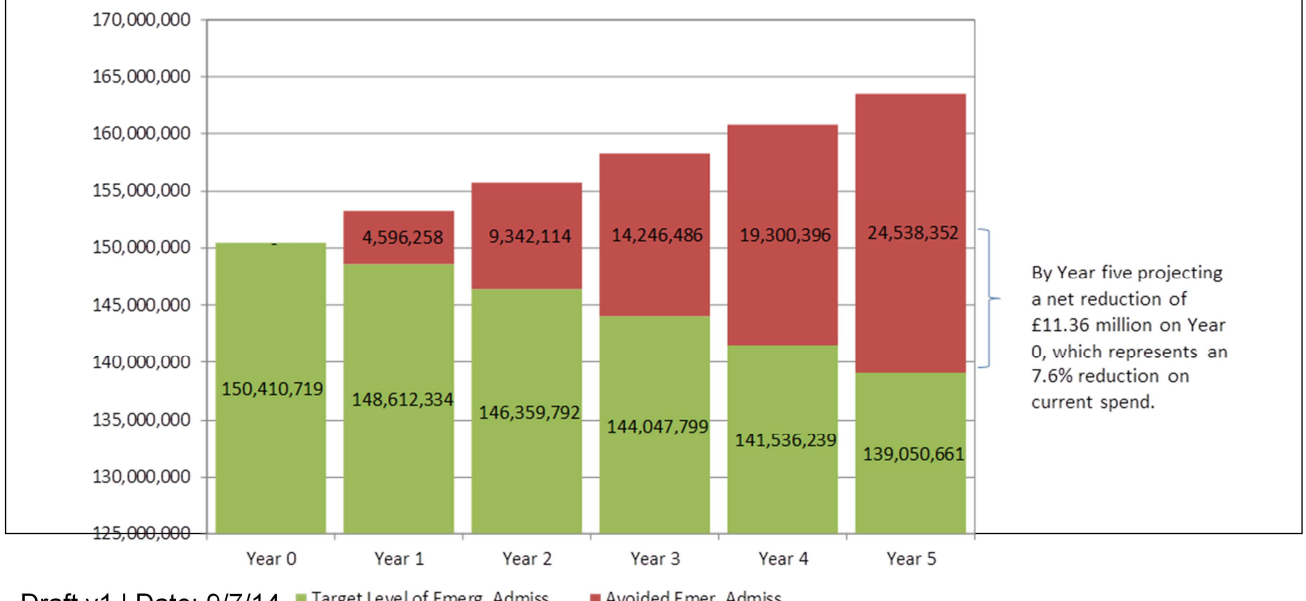
	be unable to pick up increased demand as care moves away from acute settings.		patient/service user care.	Fund will be used to increase capacity in community and social settings.
Medium	It may be impossible to realise plans because Leeds CCGs are not the primary commissioner for all primary care services and are dependent on NHS England Area Team Specialist Commissioning plans.	Unlikely	The plans cannot be implemented as anticipated and thus do not deliver their expected outcomes.	NHS England are part of ICE and Transformation Board
Medium	The lack of detailed baseline data and the need to rely on current assumptions.	Possible	May mean that financial targets are unachievable.	Proposals are based in all available information and will be refined as work progresses.

Given there is no additional money, if activity (e.g. emergency admissions or permanent admissions to residential care) is higher than planned, how will this be paid for from within existing resources?

Leeds has identified £1992k for 2015/16 to act as a contingency fund should activity be higher than planned. This figure has been arrived at following a risk base assessment. This resource is flexible; should activity levels decrease as anticipated, it can be used to fund further schemes in 2015/16 that are being scoped and developed in 2014/15.

What would be the financial impact if activity continues to grow at historical trend? How will this be met financially?

If Leeds 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. As such, 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.



It is important to recognise that the BCF alone will not solve Leeds' challenges and accordingly, it must be seen as part of the wider work across the health and care system, including the Transformation Programme. Fully understanding funding and patient activity flows to build a sustainable system is a key priority for Leeds' Directors of Finance Forum, which will be using Pioneer freedoms and flexibilities to test out new contracting and payments mechanism. We recognise we must act together as a 'virtual organisation' to meet our financial challenge.

The work to be undertaken to understand the financial implications of this anticipated reduction in emergency admissions recognises that significant activity changes like this might result in destabilisation of individual organisations. The health economy is committed to working together to understand the rate at which costs will be released as activity changes, which could well be at a different rate from tariff income changes. This potentially destabilising impact will be managed in the round, through the concept of the "Leeds £".

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
01
Scheme name
Reablement
Overview of scheme
We acknowledge that increases on demand on the Re-ablement service mean that the Re-ablement service needs to increase capacity if it is to meet this demand. We intend to expand reablement through the transfer of staff from long term community support aimed at increasing productivity. The impact of this additional capacity on waiting times will be tracked through the introduction of a data gathering process which tracks the whole process from service request to assessment visit to service start and end dates (Caretrak). This data can be reported on an area by area basis to compare and measure consistency across Leeds and will also be able to isolate hospital discharge and community referrals. This can be used to develop a baseline for future activity and the baseline can be used to identify target response times to support the integration of the Re-ablement service with Intermediate Care. The CareTrak system will be used to look at the antecedents prior to entry into the Re-ablement service and the impact post discharge from the service in terms of unscheduled hospital admissions and readmissions. As part of the development of the service specification for the integrated service (Known as L.I. L.T.), specific KPIs will be used relating to impact on hospital activity.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
The evidence on reducing costs on more expensive services by reducing demand through reablement are well documented We expect a reduction in LOS and Admissions of 5% The principles that the Clinical Commissioning Groups and Leeds ASC expect to be delivered through applying the BCF to reablement are: • Ability to demonstrate that short term investment has the potential to lead to long term change for the future, supported by agreed performance metrics to show what has been achieved. • Ability to demonstrate [inc. metrics] via service delivery: a) True integrated working b) Patient/user care benefits, c) Improved whole system working, d) Reduced duplication e) Fewer hand-offs

- Ability to demonstrate [inc. metrics] across the whole system:

    f) Improved productivity,
    g) Improved value for money
    h) More efficient services

These principles were initially outlined in the 'Smoothing the Pathway' and the 'Local Authority Proposal Adults and Children's Services' papers agreed between NHS Leeds and Adult Social Care which outline the specific schemes that were being supported by the transfer of monies covered by the previous s256 agreements.

The key success factors including an outline of processes, end points and timeframes for delivery

Service development work undertaken by NHS Leeds and Leeds ASC for long term change towards service integration must be supported by agreed performance metrics, reported on a regular basis - to show what has been achieved, and what work remains to be done.

The following metrics will be used to monitor the short term objectives

- Reduced hospital admissions
- Long term care placements
- Long term homecare packages
- Reduction in Length of stay in ICTs
- Increased throughput in ICTs
- All patients picked up by Local Authority within 48 hours of approval by gatekeeping panel
- Reduced number of delayed discharges
- Reduction in number of homecare hours being picked up by intermediate care teams

The reablement service also currently gathers the following metrics which will be considered going forward for both the Reablement Service and ICT:

Service activity

- Number of Assessments completed
- Volumes [in/outflow]
- Proportion of customers diverted to re-ablement from long term care
- Percentage of referrals, respectively, from community and hospital
- Number of packages of delivery of service completed
- Service duration [average length of service programme]
- Average length of intervention and number of hours delivered per package per week
- Reduction in delivered hours

Quantitative Outcomes [post reablement]

- No service
- Reduced service

- No change
- Increased package
- Non-completers
- De-selected

Qualitative outcomes [post reablement]

- ASCOT direction of travel questionnaire responses
- Outcomes of intervention, including impact on individual and impact on other service usage

Consideration will also be given to establishing longitudinal records, in order that the long term impact of services can be monitored. The recent DH consultation document proposed the following measure: 'proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into reablement or rehabilitation services

It is intended that the team will be integrated in 2015/16

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

This will be through the Better Lives through Integration Board, jointly chaired by Leeds ASC and Leeds Community Healthcare, who will also refine the above metrics to ensure they are fit-for-purpose for both organisations, and to add any additional required metrics as work develops.

The Reablement/ICT Integration Project Board will provide quarterly reports on the above high level metrics to the the Better Lives Board, which will in tern report through the Transformation Board and link to the Health and well Being Board

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:

- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

As per metrics spreadsheet:

1) Average elderly acute admission cost is £2,500. 'Individuals who access reablement services will be less likely to be re-admitted to hospital (assuming 840 new clients access the service, which if untreated who have had a 20% risk of readmission and on treatment have a 10% readmission rate)
2) The expectation is that there will be a threefold increase in throughput of the reablement service by April 2015. The city has a trajectory to reduce the number of permanent residential admissions by 48, this year. Our estimate is that this scheme will contribute 10 to this service.

Scheme ref no.
02
Scheme name
Community Beds
Overview of scheme
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.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
£5.3M for the provision of 121 units of nursing and residential short-stay community beds. The beds are currently all operationalised and work is being driven through the Leeds Transformation Programme (community Beds Strategy) to improve the performance of the beds and the outcomes for service users/patients. 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. This is part of the Leeds Neighbourhood Integrated Health and Social delivery model. Improved throughput through the beds through care management by the Leeds integrated Neighbourhood Teams model will meet growing demographic demand and reduce delayed discharges. An increased focus on timely admission avoidance both from the community and from A&E/ short stay assessment areas will see more care provided closer to home and fewer inappropriate acute admissions. Leeds progress to also be monitored through participation in the 2014 national Audit of Intermediate Care.
The key success factors including an outline of processes, end points and timeframes for delivery
The key success factors are:- 1 Reduction in length of stay (LoS) of all individuals accessing the service 2 Number of individuals discharged from the service 3 Bed Occupancy Levels 4 Number of days closed to admissions. 5 Number of Incidences reported to infection control. 6 Improvement in Therapy Outcomes Measures (TOMs) scores and EQ5D Health Status scores from admission to discharge 7 Reduction in the number of older people transferring directly to long term care 8 % service users discharged to hospital from the beds (admissions and re-admissions) % of these originally admitted from the community % of these originally admitted from hospital 9 Number of acute readmissions to hospital within 72 hours of admission to the service (for service users that had originally been admitted from hospital) 10 Number of days delayed discharge from service due to inability to discharge a patient/service user 11 Customer satisfaction during stay in unit prior to discharge 12 % receiving Tier 1 Falls assessment % with 3+ score on FRAT receiving Tier 2 assessment 13 Circumstances/ services received of service users prior to unit and 3 months and 6 months post discharge from the service 14 No. of people in long term care/ receiving an intensive level of care 3 months and 6 months post discharge from the service

15 No. short stay hospital attendances 3 months and 6 months post discharge from the service
16 Increased proportion of users from the community in relation to those discharged from hospital

In terms of timeframes, the community beds are already operational with ongoing monitoring of the above.

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The development of a Leeds Community Beds Strategy as a component of the wider Leeds Transformation Programme ensures that a joined up approach to development has taken place and that the development of community beds in viewed within the context of :-

- Support self-management of care
- The local integrated health and social care model of care (including Primary Care)
- Vertical integration (including admission and discharge initiatives) with the acute hospital trust

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:

- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

The impact:-
Maintaining this level coupled with remodelling/pathway improvements could impact as follows:-
Currently approx. 35% of CIC placements are admission avoidance (65% hospital discharge)= 759 placements. With an aim of stretching performance to achieve 50% admission avoidance in 5 years (by April 2019) as opposed to the current 35%, this would equate to 1165 admission avoidances per annum, an increase of 406. Typical acute HRG for CIC patient is £2,500 (not including A&E costs, transport etc.). 406 x £2,500= £1M potential saving per annum

An incremental rise is expected towards this potential level of recurrent savings:-
April 2016 £0.25M
April 2017 £0.4M
April 2019 £1M

Scheme ref no.
03
Scheme name
Supporting Carers
Overview of scheme
Support to Carers This includes Carers supporting people across a range of client groups: Older People (Inc. Dementia) Learning Disability, Mental Health, Children with Complex needs, Disabled people and Child Carers Support to Carers allow people to continue in their caring role, allowing people to stay at home, remain independent and take part in communities
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
The funding will support a range of initiatives, notably: • Respite Care (both bed based, Community based and within own homes) • Flexible support Inc. Direct Payment models • Information and advice • Access to training • Peer Support • Health and well Being support for Carers • Support to stay in employment • Support in Hospitals • Taking referrals from and support to Primary and Community Health Services • Support to neighbourhood teams and services • Support to recently bereaved carers • And additional activity (Inc. Assessment required under the Care Act The impact on Carers and evidence on supporting the Health Economy is substantial (see National and Leeds Carers Strategy) Effective Carers services will reduce inappropriate entry into hospital (5%) Reduced length of stay through effective Carer engagement in hospitals and across the pathway (2%) More Effective Discharge and reduced re-admissions (5%)
The key success factors including an outline of processes, end points and timeframes for delivery
Engagement with Carers at every level – both in regard to individual caring role and at a service and strategic level Carer Led delivery of services Understanding of the impact of Carers on the whole system

Understanding of impact of carer health Recognition of Carers as equal partners in the planning and delivery of support for the cared for person Establishment of one carer point of contact number achieved in 2014 Expanded Respite provision (across different models) 2015 Implementation of Care Act in regard to Carers 2015
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
This is steered through the multi-agency Carers Strategy Implementation Group which in turn informs and is informed by city wide strategic groups including those associated with client groups (Learning Disability, Mental health, Dementia etc.) and wider strategic partnerships (Urgent Care Board, Transformation Board, H and WB Board)
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
2016 Increased Carer Services and Carer Satisfaction - this will support the reaching of targets identified in other business cases 2017 As above 2019 As above 2021 As above

Scheme ref no.
04
Scheme name
Equipment Service
Overview of scheme
Delivery of Community Equipment (inc. Telecare) through an integrated Health and Social Care Team to support people to stay/gain independence. Linked to Scheme 16 where we will invest further to expand cover to 7 days per week.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

To support significant investment in community equipment (Health and Social Care) to support safe hospital discharge and people to remain at home safely and independently.

Service Aims: The primary aim of the service is to obtain, deliver and install the right community equipment within agreed timescales to enable people to live independent inclusive lives. Once the customer has no further use for the equipment it will be returned/collected, cleaned and, where possible, fully serviced and then re-used.

Specific aims include:

- To provide community equipment for people to use in a variety of community settings
- To procure, purchase and lease equipment.
- To deliver and install equipment at the appropriate request of a range of health and social care assessors.
- To collect, clean, refurbish and maintain equipment and maintain equipment that is returned to the store.
- To provide advice, education and support to health and social care professionals regarding the ordering, safe use and maintenance of equipment.
- To provide information to service users, carers and public on Assistive Technologies including signposting to other providers.

Leeds Community Equipment (LCES) and Tele Care Services will provide community equipment to support and enable people to live safe, independent and inclusive lives. The service is important to the prevention agenda and provides a vital gateway to independence, dignity and well-being for many people living in the community. The provision of equipment enables safe rapid discharge from hospital and hospital admission avoidance

The service will also provide, through delivery of community equipment

- Support individuals with chronic health conditions and long term care needs to maximise independence and choice.
- Support the delivery of quality care at the end of life.

- Enable social inclusion.

The service will provide community equipment to four main customer groups:

- Adults with general Health and Social Care needs (including all impairments)
- Children with general Health and Social Care needs.
- Children eligible for NHS Continuing Healthcare Funding.
- Adults eligible for NHS Continuing Healthcare Funding (CHC)

Service Standards

- To deliver and install standard community equipment within 7 days of request by Health and Social Care Professionals. To deliver and install Tele care equipment to TSA standards.
- To deliver and install standard community equipment within 24 hours of request by Continuing Healthcare.
- To deliver and install standard community equipment within 48 hours of request by Intermediate Care Teams, Hospital Discharge Teams, Re-ablement Teams and Children's Services (end of life care for children).
- To deliver and install non- standard community equipment within 2 weeks of item received in store.
- To maximise value for money and efficiency through re-utilisation of community equipment.
- Ensure that the equipment store's management systems meet the relevant health and safety standards.
- Ensure performance management and quality assurance systems are in place.
- Ensure that the equipment purchased and supplied is of a high standard and meets specifications as agreed.
- To respond to faults of Telecare Equipment within 24 hours and low battery alerts in a timely manner.
- To maintain equipment in accordance with legislation and manufacturers recommendations including portable appliance testing (PAT) on equipment returned to LCES and related record keeping on certification
- Ensure staff working within the Leeds Community Equipment and Tele Care Service, are fully competent and trained in relation to all equipment, to deliver a high standard of service.
- Ensure disabled people, including service users accessing the Leeds Community Equipment Service are consulted and engaged in the delivery and development of LCES.
- Provide comprehensive, up-to-date, accessible information for potential and actual

community equipment customers.

- Ensure an effective system for reporting adverse incidents is in place.
- To work in partnership with the Leeds Disabled Living Centre.
- To be responsive to changing requirements for community equipment as identified by statutory regulations.
- Work with other assistive technology services across health and social care and the third and independent sector.
- To engage with assessors, equipment manufacturers and suppliers.
- To provide opportunity for assessors to view equipment across the Service by appointment.
- To provide 24 hour telephone monitoring centre for Tele Care customers, ensuring a response is given to an alert is raised if the sensor activates or detects any problems.
- To provide accurate information about current stock in stores, including service and maintenance history, on request

Service Objectives

Service users receive their equipment in a timely manner, and are given guidance and information on safe use of equipment -

- Assessors are informed when specific equipment, which requires fitting and training by the Assessor, is delivered.
- Assessors receive information about the service.
- Service user feedback and complaints are used to inform onward development and improvements to the service.
- Incidents and near misses are reported in accordance with Local Authority, NHS and national reporting requirements.
- The services are compliant with MHRA Medical Devise guidance, the Local Authority and NHS Infection control and Prevention policies to ensure that the risk of contamination and cross infection is minimized
- The Services used different methods of decontamination to address varying levels of contamination, depending on the equipment, risk assessment classification and it's use, in accordance with infection control guidance and manufacturing guidelines

Service Outcomes

1. Disabled Adults, Older People and Children can stay at home in a safe environment.
2. Paid and unpaid caters are supported and safe.

3. Statutory organisations' risks are managed.
4. Assessors are skilled and working efficiently.
5. The service shall be responsive to the needs of Service users and assessors.

We intend from November 2014 to deliver this from a purpose built facility, linked in to associated services this will include developing high end technological solutions in including greater use of Telecare, and Information Management Technology and emerging technologies (inc. health and well-being apps and higher end equipment (e.g. glance technology)

The new build will in future establish and support innovation including a Retail Unit, 'Smart House and 'Innovation Lab' (This will be funded through external partner investment).

There is strong evidence from both local evaluation of the existing Community Equipment service and the national guidance that effective equipment services reduce demand on acute care, particularly in regard to effective and speedier discharge. This includes:

- Integrating Community Equipment Services, DH (2002)
- Transforming Community Equipment Services (TCES) June 2006
- The Department of Health guidance
- NICE guidance
- MHRA advice and alerts
- HSE legislation
- Putting People First (Transforming Adult Social Care)
- A Vision for Adult Social Care: Capable Communities and Active Citizens
- Vision for Leeds 2011 – 2030.
- The Time Of Our Lives: Ageing Well in Leeds
- CECOPS 2012 – Community Equipment Code of Practice
- TSA Code of Practice – Telecare Services Association

We would expect that to continue at 10% of discharges being able to me quicker by 5% - 20%

The key success factors including an outline of processes, end points and timeframes for delivery

- Integrated Services
- Pooled Budget

- Expansion into new technologies
- Information on options
- Opportunities to display and test equipment

The service will deliver on a range of services for Children and Adults:

Adult Equipment

- The service will ensure that equipment is purchased using appropriate and robust procurement arrangement.
- The service will stock/store both new and re-cycled equipment at the main store and limited equipment in identified peripheral stores around the city.
- Re-cycled equipment will be reviewed based on the length of time it remains in store without being reissued and a decision made on retention or disposal.

Children's Equipment

- The service will stock/store both new and re-cycled equipment at the main store and limited equipment in identified peripheral stores around the city.
- Re-cycled equipment will be reviewed based on the length of time it remains in store without being reissued and a decision made on retention or disposal.

Adult Continuing Care

- The service will ensure that equipment is purchased using appropriate and robust procurement arrangements.
- The service will stock/store both new and re-cycled equipment either at the main store and limited equipment in identified peripheral stores around the city.
- Re-cycled equipment will be reviewed based on the length of time it remains in store without being reissued and a decision made on retention.
- Provision of a dedicated enhanced Planned Preventative Maintenance Fitting service for Adult continuing care (1 WTE post)

Telecare and Care-Ring

- The service will ensure that equipment is purchased using Local Authority procurement arrangements.
- The service will stock/store both new and re-cycled equipment at the main store in the city.

Timetable:

- Maintaining current funding – 13/14
- Formalising and expanding joint delivery arrangements between LCC and LCH – April 2014
- Fully jointly funded service with Pooled Budget arrangement between LCC and

CCG's April 2014
- New build to operate integrated service open November 2014
- Expansion into new technologies 2015-17
- Smart House/Innovation lab – 2017/18

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Through existing integrated Commissioning and delivery boards for equipment services Linked to service areas and wider Transformation Board and H and WB Board

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:
- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

Further work is being done to better understand this.

Scheme ref no.
05
Scheme name
Third Sector Prevention
Overview of scheme
Leeds has a vibrant third sector, supporting citizens and service users to stay well, maintain independence and lead an active, safe and engaged life within communities This includes a strong focus on services for older people, people with mental health needs, learning disability and Long Term Conditions Maintaining funding for these services will enable the continued support to individuals and the increasing integration of these services within health and social care pathways
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
This area covers a huge range of interventions across client groups and communities Key areas include: Neighbourhood Networks – particularly services to tackle loneliness and Isolation and Healthy and Active Life (Inc. Exercise, Malnutrition/Hydration) (as outlined in the Institute of Public Policy Research document – Generation Strain and numerous papers on Older People's well-being) Community and User Led Mental Health Services (NSF for mental Health, Mental Health Framework) Dementia Services – See Prime Ministers Challenge/National (and Leeds) Dementia strategy Sensory and Physical Impairment services (National Vision Strategy, RNID Health impact of hearing Loss etc.) Advocacy – (See The Care Act) Leeds Directory – Information o services (Care Act etc.) Social Prescribing (testing and developing new models) All of these, and many more funded through LCC and CCG's and partner funders, create a community of support, allowing people to avoid unnecessary hospital avoidance (5-10% of relevant client group) reduced Length of stay (10% esp. in older people's and mental health facilities) and provide more effective discharge and reduced re-admissions (10%)
The key success factors including an outline of processes, end points and timeframes for delivery
Key are: Co-production between commissioners, community organisations and communities Sustainable funding Outcomes focussed commissioning Asset Based Community Development approach Investment in expanding Community Capacity

All of these services are part of an ongoing commissioning cycle – Identify Needs, Plan service type, Implement and then review The BCF will allow for this to be maintained, whilst enabling a shift towards a stronger focus on invest to save for the health economy
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
Through the cities partnership boards and joint working/integrated initiatives These are at both specific service area/client group level (Dementia Board, Mental Health Board) and at a macro level: Transformation Board, Health and Well Being Board
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
April 2016 Continued Hospital Avoidance as outlined above 2017 - this will support the reaching of targets identified in other business cases 2017 As above 2019 As above 2021 As above

Scheme ref no.
06
Scheme name
Admission Avoidance within LTHT
Overview of scheme
To reduce the impact of unplanned admissions within the acute trust through improving management of patient flow within A&E and enabling effective assessment prior to decision to admit.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
Flow managers within A&E, effective triage by Consultant geriatrician in A&E, provision of pre admission assessment units and effective early support discharge team - a multiagency team including community health practitioners within LTHT. (linked to scheme 16 where the EDAT team is being funded to extend their working hours and cover 7days per week).
The key success factors including an outline of processes, end points and timeframes for delivery
Reduced number of people who attend LTHT as an unplanned attender will be admitted. Efficient assessment within A&E, transferred for assessment as required. People will be fully supported to access the right care in a timely way out of hospital. Improved access to expanded community services.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
This scheme is closely linked to both the Admission and Discharge Group, the Transformation Board and the H&WBB.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Further work is currently underway to fully assess the impact.

Scheme ref no.
07
Scheme name
Community Matron
Overview of scheme
Currently community matron services in the city are funded by CCGs and are core part of the integrated neighbourhood teams. Transferring this service into the BCF will support further enhancement and integration of this service into the wider integrated health and social care model.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The community matron service is well-established in Leeds. Community matrons work as an integral part of the Integrated Health and Social Care teams to ensure each patient has a carefully coordinated personalised plan of care based on a holistic assessment of need using their advanced skills and referring on as appropriate. All Community Matrons manage an active caseload of ca. 50 adults with long term conditions. Patients are proactively identified using the risk stratification tool, local intelligence and other professionals through local MDT processes

Future developments and proposals for expanding the service are set out separately in scheme number 16. These developments aim to:

- Fully embed proactive case management processes
- Increase service capacity & efficiency
- Complement the primary care schemes in reducing admission, readmission and supporting safe and timely hospital discharge.

Background & evidence Base
The population of Leeds is estimated at > 800,000. The emerging common issues for Leeds include; changes in population (80% of the population are under 60 years of age, 24% aged below 20 years of age, nearly 16% of the population are over the age of retirement –below both national and regional averages), diverse communities, city-wide variation in need (adults and older people, carers), health inequalities, mortality and deprivation. People aged 65 and over make up approximately 16% of the Leeds population but occupy almost two thirds of general and acute beds. National policy aims to prevent avoidable and inappropriate hospital admissions particularly for older people and those with Long Term Conditions (LTCs).

People with LTCs are amongst the most intensive users of health services and with an ageing population the number of people with at least one LTC is rising. The incidence of people with more than one LTC is also rising, and leads the focus of commissioning services from disease-specific pathways to a holistic approach with a focus on co-morbidities. They account for more than 50% of all GP visits and over 70% of all in-patient bed days. Deterioration in physical status and independence in daily living can

have a significant impact on both physical and mental health, social and psychological function, leading to increasing dependence on health and social care services. Effective interventions are required in the management of long term conditions to help individuals lead an active life without the need for emergency care and/or hospitalisation.

Service Model:

Community Matrons pro-actively manage patients with long term conditions within a model which includes;

- Utilisation of the risk stratification tool to identify a list of patients who are at high risk of admission in the next 12 months and would most benefit from a pro-active planned approach to their care with integrated working between primary, community services and the local authority.
- Promoting self-care for patients through innovative interventions, information and education.
- Implementation of personalised care planning that put people at the centre of decisions about their care with a focus on goal setting, holistic needs and prevention.
- Care co-ordination and pro-active clinical case management of complex patients

Every GP practice has a named Community Matron(s) who will have a lead role in working with the GP practice to provide effective management interventions to reduce the risk of unplanned admission for patients with high/moderate risk. This is part of the Integrated Health and Social Care Team, working through the MDT approach with practice populations. Community Matrons are autonomous practitioners who utilise core competencies outlined by the NHS Modernisation Agency (DOH 2005) and as described by Skills for Health to plan and coordinate ways of meeting all health and social care needs of specific groups of people with long term conditions. This creates a person centred approach and support people to take responsibility for their own condition and encourage self-care to improve health outcomes and patient satisfaction.

The key success factors including an outline of processes, end points and timeframes for delivery

- Reduction in avoidable/inappropriate A&E attendances
- Reduction in inappropriate use of out of hours services
- To promote patients independence and self-management of their condition(s)
- People feel safe and confident with management of their condition.
- More people are supported to remain in their own home.
- Reduction in admission/readmission to acute settings where appropriate
- Reduce GP visits to patients on the caseload where appropriate

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The service is a key part of the Integrated Health and Social Care Team model. Planned further develops to the service (as outlined in scheme 16) are core components of the CCG and adult social care commissioning plans.

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:

- **April 2016**
- **April 2017**

• **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Impact still being reviewed in light of scheme 16.

Scheme ref no.	
08	
Scheme name	
Social care to benefit health	
Overview of scheme	
This is the NHS England transfer from health to social care. This fund is to be used to enhance social care services that have a direct impact on health and care for Leeds people.	
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)	
It is currently proposed that this scheme is composed of a number of different areas as follows for 14/15 and 15/16 (subject to final agreements):	
Housing Care & Support - Residential Care	The planned reduction in the cost of placements is not falling at the planned rate. This appears to be due to the increased levels of placements direct from hospital. For the first four months an additional 24 people have been placed over last year. These 24 have an average net cost of 16,250 per annum, or £390k for the group. If the trend continues then an annual cost of £1.17m will be generated. This represents a 9% growth on 2012/13 placements from hospital, and it is worth noting that the 12/13 figures were themselves some 13% higher than the previous year.
Housing Care & Support - Home Care	Home care hours: there is a significant growth in home care hours. ASC are paying for an extra 50 hours per week since April. One identified cause is the discharges from hospital. Analysis shows that in the first quarter discharge delays are falling quite dramatically. At current trends the financial pressure for externally procured homecare is £2.6m.
Early Help and Intervention - Therapeutic Social Work Team	Expand the Therapeutic Social Work Team
Workforce, Education and Training - Outcomes Based Accountability and Restorative Practice, City-wide Implementation and Training Programme	Restorative practice is a whole system approach about building, maintaining and repairing relationships with the fundamental premise that people are happier, more co-operative and productive, and more likely to make long-term positive changes when those in authority do things with them, rather than to them or for them. Restorative Practice can help to build social capital and a sense of community in all settings, from schools, children's homes, health, police, social care, partnerships and communities and through which all partners can have a common approach that cuts across disciplines to work and improve outcomes for children, young people and families.
Information and Knowledge - Social Care Records System	Exploiting the opportunities of the new 'Framework' system to allow access to critical safeguarding information about individual children securely and appropriately within

	hospital settings and significantly improve information sharing, reduced duplication and co-ordinated care and referrals across partner agencies.
Better Lives - Early Retirement/Severance	Voluntary Early Retirement/Voluntary Severance: in transforming services, there is the necessity to downsize the workforce, last year ASC incurred severance/early retirement (one-off) costs of £1.7m. In 13/14 £250k has already been spent on severance/early retirement, principally representing community support, day services and residential homes services. The anticipated in-year financial cost is anticipated to be £1.0m. The removal of these posts is expected to deliver a financial efficiency within 5 years of the initial one-off costs
Housing Care & Support - In-house Older People's Day Centres	The older person's day services are currently running at 54% of capacity. Although phase 1 of the strategy has been implemented including a number of closures of existing centres, further plans are being developed to more closely align future capacity with both current and likely future demand. The level of voids, during this transitional period (46%), equates to approximately half of the direct running costs of the day centres (£1.2m)
Housing Care & Support - In-house Older People's Residential Homes	The in-house residential homes service is currently running at a void level of 58 beds (14 % of permanent beds); this is equivalent to 2 whole residential homes. The annual, average, net direct cost of 2 residential homes is £1.2m (net of assumed client contribution and excluding departmental and corporate overheads and capital charges).
Housing Care & Support - Learning Disability Day Centres	The learning disability day centre review (Fulfilling Lives) has incorporated an additional £0.5m pump-priming funding to develop third sector provision. Whilst developing and supporting the transition of service users to these new services the Authority is supporting voids at 17%, this equates to £0.9m of the direct cost of providing day services for learning disability service users during this transitional phase.
Housing Care & Support - In-house Older People's Residential Homes	The older people's residential review has necessitated a 'Task & Finish Team' of care managers and social work assistants to assess the needs of all the clients affected by the transformation of services. The cost for the 2013/14 year is estimated at £0.2m.
Integration - CareTrack	The CareTrack system is starting to provide very valuable information across the health and social care system to inform activity planning and financial modelling. LCH and the CCGs are starting to identify the benefits of this information. The costs for licenses, data input and analysis, including a significant input of staff time, is estimated to be up to £200k.
Integration and Partnership - Increasing support for parents with drug and alcohol and Mental Health Issues	Dedicated resource to work with partners in Adults Social Care and Health to support families who are experiencing issues around drug and alcohol misuse.
CAMHS service risks	*To support to the jointly commissioned CAMHS service; this is to ensure that a rigorous review will identify the safest method of delivering the required saving on a recurrent basis (as set out in the LA children's budget*

	setting).
***JADAR** apply agreed formula to current caseload*	*This pays in full the 2013/14 health contribution for children on the JADAR caseload.*
***Early Help and Intervention** - Family Group Conferencing*	*Linked to the whole Restorative Practice approach, expand Family Group Conferencing to ensure a consistent city-wide offer where children and families are supported.*
***Early Help and Intervention** - Kinship Care Teams*	*Linked to Restorative Practice, the expansion of Family group Conferencing and the Kinship Care offer, to expand the Kinship Care Team to ensure that adequate support is in place to maintain positive outcomes and prevent escalation.*
***Early Help and Intervention** - Targeted locality-based Services*	*Build on the strong foundation of the Children's Centres and Early Start Service. Continue to invest in targeted evidence-based services that make a long-term difference to children and families, such as Multi-Systemic Therapy, Signpost Family Intervention Programme and Family Intervention Services*
***Integration and Partnership** - Children with Complex Needs*	*Integrated education, health and care planning particularly around transitional planning for children with a statement of Special Educational Needs with direct links to the introduction of personalised budgets.*
***Child-Friendly City** - putting children and young people at the heart of everything that we do.*	*Leeds is committed to becoming the best city in the UK and as part of this vision to become the first truly child-friendly city in the UK. Across partner agencies we need to demonstrate how we listen and involve children and young people.*
***Vulnerable Children** - Children at risk of sexually harmful behaviour*	*Dedicated resource to work with children and young people who are at risk from sexual exploitation or sexually harmful behaviour.*
The key success factors including an outline of processes, end points and timeframes for delivery	
The details for each of the components of this scheme are currently being developed.	
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care	
All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.	
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**	
The key aim of this scheme and the sub schemes is to protect social care capacity. The details for each of the components of this scheme are currently being developed.	

Scheme ref no.
09
Scheme name
Disabilities facilities grants – Rob McCartney providing more info
Scheme name
Disabled Facilities Grants (DFGs) are a mandatory entitlement for disabled people to adapt their homes to create an accessible living environment. Every housing authority has a legal duty to deliver adaptation schemes where such works are considered 'necessary and appropriate' to meet the disabled person's needs and it is 'reasonable and practicable' to make the changes to the person's home.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
A local authority receives the government funding to help fulfil the legal duties of the housing authority. Adaptations play an important role in helping disabled people to live independently and therefore reduce the likelihood of hospital or residential care placements; DFGs are therefore an important intervention towards meeting Leeds' BCF plan objectives.
The key success factors including an outline of processes, end points and timeframes for delivery
This scheme relates in interventions on an individual level and run through the year. Target timescales are set for individual adaptation works to be completed with different timescales set for work based upon a priority status. The time measure is between first date of approach and date of practical completion. The local timescales for Leeds are significantly more demanding than those set out in adaptation government guidance.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Work is currently underway to understand this.

Scheme ref no.
10
Scheme name
Social care capital grant - Care bill
Overview of scheme
On 16.7.14, Leeds City Council's Executive Board will consider proposals for additional capital funding to implement the information and management requirements of the Care Act. Approval is being sought from the Executive Board for a £1.652 M capital funding (including £744k social care capital grant allocation within the Better Care Fund) to use technology innovatively to increase capacity to help offset the anticipated demand in assessment activity. This will include: the development of on-line options for self-assessment; personal accounts and to develop electronic methods of data transfer of care information between authorities to facilitate portability of assessments.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
TBC following approval from the Executive Board – 16th July.
The key success factors including an outline of processes, end points and timeframes for delivery
TBC following approval from the Executive Board – 16th July.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Work is currently underway to understand this.

Scheme ref no.
11
Scheme name
Enhancing primary care
Overview of scheme
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.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
Work is currently underway through 14/15 to develop the business case and as such we are not able to complete a full business case at this stage.
The key success factors including an outline of processes, end points and timeframes for delivery
Work is currently underway to understand this.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Work is currently underway to understand this.

Scheme ref no.

12

Scheme name

Eldercare facilitator

Overview of scheme

Redesign of dementia pathway and creating “elder care facilitator” role. This proposal is about co-ordinating diagnosis and self-management support in primary care.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

- Bring memory assessment, diagnosis and management of dementia into the GP practice setting
- Reduce stigma and barriers and create more holistic management of physical and mental health, in line with NHS Mandate.
- Create the role of “eldercare facilitator”1, one FTE for each of the 12 neighbourhoods, to work as part of primary care team. The role could be provided by third sector or an NHS provider, but would require ‘honorary contracts’ to work within practices and access systems.
- To support memory assessment; befriend and build trust; promote positive attitudes to living well with dementia; and inform and connect people and carers reliably and consistent to post- diagnosis support.
- Old age psychiatry and memory service clinic sessions to take place in GP surgeries, working as a virtual team with GP practice and eldercare facilitator.
- Revise memory service specification to: facilitate this closer link to primary care; include a standard of post-diagnosis education and non-drug treatment (cognitive stimulation therapy); and simple access back to the service when needed.
- Review local guideline for Donepezil and other Alzheimer medication, to streamline routine reviewing within primary care. This would: complement the overall local agreement for enhanced GP service covering all “amber drugs”; make clear the requirement to use Donezepil as most cost-effective AChEI2 option, unless e.g. contraindicated / poorly tolerated.
- Use eldercare facilitator role to support self-management plans and interventions to directly reduce acute admissions for the main causes experienced by people with dementia: urinary infections, respiratory infections, falls and fractures. Supports other primary care initiatives e.g. named GPs for people aged 75+.

The development of memory assessment and diagnosis in the GP practice setting, alongside the role of eldercare facilitator, was pioneered by Dr Ian Greaves at Gnosall surgery, and is being rolled out across two CCG areas – Stafford and Surrounds, and Cannock and Surrounds. The Gnosall model has been in operation for seven years and has:

- led to the practice knowing 100% of people with dementia estimated from practice population, with very high patient and carer satisfaction;
- enabled GPs to plan more actively to address risks of acute admission. Michael Clark at London School of Economics has published evidence that spend on acute admissions is £450K below expected average for population profile for 8,000 population (linked to a range of initiatives re. dementia and frailty).

The key success factors including an outline of processes, end points and timeframes for delivery

- It will increase the number of people with dementia and carers who can be supported by person- centred self-management; more will become known to the practice, there will be capacity to stay in touch / monitor / 'befriend' rather than people 'falling off the radar' until an emergency happens.
- Support Leeds to achieve high diagnosis rate for dementia during and beyond 2015.
- It will bring the expertise of specialist services and primary care together to achieve "the best of both worlds" for people with dementia and co-morbid conditions linked to ageing. It will avoid the duplication / fragmentation of having Alzheimers medication reviews at a memory clinic but annual dementia reviews (QOF DEM2) in primary care; and end the inappropriate, prescribing- led, variation in post-diagnosis information and support.
- Enable the qualified nurses and OTs in the Leeds memory service to deliver post-diagnosis, education, treatment and work more closely with primary and community clinical colleagues.
- Eldercare facilitators will ensure that everyone with a diagnosis of dementia, and family / carers, are offered information and connection to local support services, including financial planning / money advice, activities and day opportunities, peer support. This is a strength of what Leeds has to offer, especially in the third sector, but local evaluation has shown we do not routinely link people to it. This early support is believed (National Dementia Strategy, NICE clinical guideline) to promote well-being and independence, but is hard to quantify as cashable savings for planning purposes.
- There are c. 3,800 people aged 75+ in Leeds with a diagnosis of dementia in Leeds, with an estimated average probability of 50% for an acute admission each year. The leading primary diagnoses for this cohort are urinary and respiratory infections, falls and fractures, which are all regarded as potentially preventable causes.
- A minority of this cohort of people will be identified for "case management" by integrated neighbourhood teams. Most will require support with preventive, person-centred planning for self-management of dementia and long-term conditions, and the risks of acute illness / injury. GPs, community matrons, community geriatricians will be able to work with people and carers to identify preventive steps, with eldercare facilitators and memory service staff available to support the delivery. This will complement the initiative for named GPs for people aged 75+ (GMS contract).
- Eldercare facilitators will be able to identify when "case management" is required, work with case managers, and support transitions back to self-management (cf. BCF national conditions).

Impact on BCF National Conditions/BCF Performance Targets

- **Protection of Social Care:** not a direct support, but indirect effect of relieving workloads.
- **7 Day working:** capacity above would probably be too little for 7-day availability.
- **Accountable Lead Professional:** would sustain and support self-management cohort and smooth transitions to case management and back to self-management.
- **Impact upon Acute Sector:** this cohort of patients are among those who fare worst on acute pathways, with moves through A+E, MAU to ward and assessments at each step.
- **Emergency Admissions:** evidence of prevalence of potentially preventable admissions. Delayed Discharges
- **Effectiveness of Reablement:** offers support for step-down from intermediate

care to daily living.
- **Potential Local measures:** increase dementia diagnosis rate (though timescales will depend on procurement and recruitment for March 2015 target)

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Use the following outline timetable to indicate what impact you expect BCF schemes to have by:
- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

This will impact of acute admissions and contribute significantly to "Everyone Counts" requirement to reduce acute admissions by 15% over 5 years.

2015-16: 1,200 people with dementia with preventive person-centred plans in place – 100 fewer acute admissions.
2016-17: 2,500 people with dementia with preventive person-centred plans in place – 250 fewer acute admissions

Further impact over 3-5 years from getting better at preventive care planning; and longer-term effects of increased diagnosis and early support.

Scheme ref no.
13
Scheme name
Medication prompting (dementia)
Overview of scheme
Medication management and memory problems. To meet the needs of a cohort of people who cannot manage their own medication and do not have informal care or care services available for support.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
This proposal is not developed enough to specify a service model, but probably the simplest solution is to add capacity to community nursing teams within the LCH contract. However, there are alternatives e.g. using the adult social care framework for domiciliary providers, or an innovative approach working with medicines management / community pharmacy / third sector. The service should make best use, when appropriate and safe, of assistive technology An NHS pilot in the West Midlands in 2011 reported success using automated pill dispensers. http://www.westmidlandsiep.gov.uk/index.php?page=26&iID=1062. However, such devices can increase confusion for some people with dementia); and of community capacity (e.g. good neighbours), which would have the added benefit of reducing social isolation. There may be opportunities to link this to other self-management support: For example, when people do not take medication for other reasons (not understanding why it's prescribed, not believing its helping them, side-effects), the capacity for conversations to promote concordance. The Leeds Memory Service reports that it is an issue they routinely encounter in practice, that it is difficult to arrange a medication prompt so that they can prescribe Donepezil (Aricept) and other related drugs for people diagnosed with Alzheimers disease, who have no-one available to prompt medication - usually those who live alone. The memory service do always try assistive technology as a solution, with variable success. Probably a greater risk to well-being is when people with memory problems (which can be linked to a range of conditions, eg. depression or nutrient deficiency as well as dementias) are prescribed medication to control eg. diabetes, hypertension, cholesterol. 90% of people with a diagnosis of dementia have at least one other "Year of Care" long-term condition. There is some disagreement within the system about responsibility for prompting medication and the Better Care Fund represents an opportunity for an integrated approach. Adult social care policy is to offer a medication prompt as part of a larger care package, but not as a standalone service – (this is a long-standing policy, but it appears to assume that difficulty with medication will always be below the "Substantial" threshold on the eligibility framework). Leeds Community Healthcare are commissioned to

provide a level of medication prompting from community nursing teams, but report that this capacity is full with a waiting list, and believe they are not commissioned to provide sufficient capacity.

The Social Care Institute for Excellence (SCIE) has reported that:

- Forty-five percent of the medications prescribed in the UK are for older people aged 65 and over, and 36% of people aged 75 and over take four or more prescribed drugs. It has also been found that as many as 50% of older people on prescribed medication may not be compliant with the prescribed regimens, that is, taking their medicines as instructed. http://www.scie.org.uk/publications/briefings/files/briefing15.pdf
- NICE have stated that the costs of admissions resulting from patients not taking medicines as recommended is estimated to be between £36 million and £196 million in 2006–07 http://www.nice.org.uk/nicemedia/pdf/CG76CostStatement.pdf
- This scales to c. £0.5m - £2m pa. for Leeds, though proportion attributable to older people and memory problems is unknown.

The key success factors including an outline of processes, end points and timeframes for delivery

Work is currently underway to understand this.

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:

- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

Work is currently underway to understand this.

Scheme ref no.
14
Scheme name
Falls
Overview of scheme
This scheme has initially been funded to allow scoping work to be undertaken to understand if it is viable for further funding. 50K has been allocated to support the scoping of work to prevent falls and decrease admissions due to falls in Leeds . The proposal is to fund a person on fixed term basis to undertake a scoping exercise of the evidence base of preventing falls within the context of supporting older people living with frailty. They will also review the present service; identify gaps and good practice from elsewhere. The outcome will be a costed, evidence based option paper for reducing falls in older people in Leeds.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
Falls and fear of further falls are a key contributor to reducing older peoples independence – therefore by contributing to Outcome 2 of the JHWBS. The number of older people especially the frail elderly are predicted to rise in Leeds and therefore this issue will continue to be important. Figures from POPPI show an expected increase of 15% in the number of people having falls, and injury due to falls, in those aged 65+ in Leeds between 2012 and 2020. Admissions for falls in Leeds are high, with A&E data on injuries due to falls in Leeds higher than rest of the country. There are over 1000 injuries due to falls a month. YAS call out for falls in Leeds are averaging 90 a day for one month call per CCG were 339 calls to YAS (Leeds North); 486 (Leeds South and East),Leeds West -483. Thereby preventing falls and reducing the requirement to call YAS or for a hospital A and E attendance or admissions due falls will impact on the whole system as well as increasing the quality of life for older people in Leeds. Modelled deaths in Leeds due to falls 58; estimated hospital admission due to falls in Leeds 2495. This is the initial scoping work but if we succeed in s business case for falls in the city – estimated cost of falls in Leeds - £12m
The key success factors including an outline of processes, end points and timeframes for delivery
Work is currently underway to understand this.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The

schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Approx. 1,400 unplanned admissions to hospital by patients aged 65 and over each year for T&O. Whilst a service model has yet to be agreed, it is anticipated that effective falls prevention schemes could reduce T&O admissions by 10% for this cohort.

Scheme ref no.
15 (i)
Scheme name
This is made up of two main components. First main component is: Expand community / intermediate beds
Overview of scheme
To increase nursing CIC beds by 12 beds(7.5% increase of overall CIC bed provision) with the associated Neighbourhood Team staffing, allowing, approximately 140 additional patient CIC stays per annum.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
To increase nursing CIC beds by 12 beds (7.5% increase of overall CIC bed provision) with the associated Neighbourhood Team staffing, allowing, approximately 140 additional patient CIC stays per annum. This will support both step up and step down to enable appropriate and timely discharge of patients from hospital and avoid admissions. This includes expanding the community bed bureau to 7 days working, to allow optimum use of available community beds and to even capacity across the week. **Whole system flow** The proposal will improve whole system patient flows by providing more capacity to prevent hospital admissions and reduce delayed discharges. The increase in capacity will bring Leeds closer in line with national median benchmark of 23 CIC beds per 100,000 weighted population (Leeds currently has a steady state of 20 CIC beds per 100,000 weighted population). **Reduction in acute admissions** The proposal will also provide sufficient overall CIC capacity and flexibility to allow us to ring-fence a number of beds in the new CICU in Beckett Wing for immediate diversions from A&E and the assessment floor at SJUH. Clinician reports are backed up by recent data analysis (CCG Performance Team March 2014) that we are currently admitting to hospital on average 1.75 patients per day from A&E and elderly assessment wards who could have gone directly into a CIC bed if one had been immediately available. This equates to 420 people per year. Currently this cohort are defaulting to a full and unnecessary hospital admission (with an average l.o.s. of 4.4 days) then subsequently going on to a CIC bed on discharge from hospital. **Reduction in delayed discharges** The proposal is also intended to reduce delayed discharges due to awaiting CIC bed availability. **Geographical spread of CIC beds** In addition, this proposal could potentially allow us to provide a more even geographical spread of beds across the city (subject to market availability of beds) which would

improve patient/service user choice.

The key success factors including an outline of processes, end points and timeframes for delivery

BCF National conditions

1. Plans to be jointly agreed. The proposals respond to the implementation of the Target Operating Model for integrated adult health and social care services, which has been agreed at multiagency Leeds Transformation Board.
2. Protection for social care services. The proposals include funding for health and social care resource as part of integrated working at neighbourhood level and to support discharge planning.
3. 7 day services to support discharge and reduce admissions. As outlined this proposal specifically increases community bed capacity to improve patient flows across the 7 day period.
4. Better data sharing between health and social care based on the NHS number The Integrated neighbourhood team model is based around a multi-disciplinary team, including both health and social care, working closely together to deliver a programme of care. The NHS Number has been agreed as the common currency between different organisations. This work is support by ongoing developments in information governance and data sharing between health and social care organisations in Leeds, lined to pioneer status and Leeds Care Record.
5. Ensuring a joint approach to assessments and care planning and ensure that where funding is used for integrated care there will be an accountable professional– integrated neighbourhood teams will have a joint multiagency and multi-professional approach to assessment and care planning, including patient and family engagement in this process. This will be supported by a case management approach, including proactive care, and named leads for patients who are being case managed within the integrated neighbourhood teams.
6. Agreement on the consequential impact of changes in the acute sector. The proposals outlined are designed to reduce the overall number of acute beds required and reduce length of stay through a more proactive, communit6y based response. The overall impact will be modelled at a programme level.

BCF Performance Targets

1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes – increasing community bed capacity and delivering the service as part of the integrated health and social care team will enable people to live as independently as possible for as long as possible in their own homes.
2. Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services. Effective discharge management and enhancing neighbourhood teams will enable people to live as independently as possible for as long as possible in their own homes.
3. Delayed transfers of care from hospital per 100,000 population. The enhanced community bed capacity will improve flow from acute to community settings reducing DTOC.
4. Avoidable emergency admissions – community beds will enable people to be maintained in a community setting, avoiding hospital admission
5. Patient / service user experience – patients and families will be supported to remain in a community setting closer to home
6. Estimated diagnosis rate for people with dementia – community teams that support community beds are attuned to the signs and symptoms of dementia and

can screen for dementia within community bed settings.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Use of ring-fence CIC beds for admission avoidance will 'divert' 1.1 admissions per day; Homeless beds - Post-discharge care planning estimated to reduce readmission rates by 20% (40 admissions per year - 50% impact for year 1)

Scheme ref no.
15 (ii)
Scheme name
This is made up of two main components. Second main component is: Homeless Accommodation Leeds Pathway (HALP)
Overview of scheme
Beneficiaries of this project will be men or women, age 16 and over who are in hospital and are homeless. This includes those who are in hostels, sofa surfing, rough sleeping or otherwise insecurely housed. The designated intermediate care beds at St George's Crypt are for those discharged from hospital with ongoing physical health concerns and who would otherwise be rough sleeping. The beds also enable appropriate discharge from hospital for those who would otherwise be unfit for discharge due to their housing status.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
There will be a dedicated referral system in to the Homeless Accommodation Leeds Pathway available 24 hours 7 days a week The project will: • Provide 3 single bedrooms designated specifically to this project. • Look after the health and care needs of each person in the intermediate care bed including food and clothing where necessary. The specialist GP and Nurse will provide health services to the patients in three intermediate care beds at the Crypt. • Provide daily (Monday-Friday) specialist GP and nursing support in hospital to homeless patients in Leeds General Infirmary and St James' hospitals. Assessment on the wards will enable appropriate care and discharge into the intermediate care beds at the Crypt. • Provide ongoing case management from specialist homeless Support Workers from the point of referral for homeless people in hospital, working with housing and other services to ensure appropriate accommodation and support is accessed following discharge. The Support Workers will work with people once in the community to avoid readmissions to hospital. • Actively work with the individuals in the Crypt beds to ensure a maximum stay of three weeks and liaise with other agencies to source appropriate accommodation for them to move in to. • Provide a detailed needs assessment for the individual upon leaving the intermediate care beds at the Crypt to aid continuity of care. • Annual cost of inpatient hospital care for homeless patients is 8x that of housed population aged 16-64 (Office of the Chief Analyst. Healthcare for single homeless people. Department of Health, 2010. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250) • Homeless people attend A+E 5x as often as housed population, are admitted

3.2x as often and stay 3x as long (*Ibid)*.

- In Leeds in 2013 254 homeless patients had 1652 bed-days in hospital at a cost of £724,020.
- There were 206 readmissions of homeless people within 30 days of discharge.
- This large expenditure does not equate to improved quality or outcomes – the average age of death of homeless people is 47 years and associated with the reduced quality of life caused by multi-morbidity (Crisis 2011. Homelessness: a silent killer. London Dec 2011. http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf)

The original pathway in London (on which this model is based) demonstrated the following outcomes:

- Homeless patients felt more cared for, and hospital and community staff, through better support, provided better integrated care.
- The strategy resulted in a total reduction of 1000 bed days (30% reduction) in the first full year of service delivery and commensurate cost savings (Hewett, N *et al.* 'Quality Improvement report: A general practitioner and nurse led approach to improving hospital care for homeless people' *BMJ* 2012;345:e5999)

The key success factors including an outline of processes, end points and timeframes for delivery

The project aims to**:**

- Improve the quality of inpatient stay and discharge for homeless people
- Coordinate integrated care following hospital discharge preventing readmission to hospital
- Improve access to health services in order to reduce morbidity and mortality in homeless people
- Improve quality of life for homeless people
- To ensure those leaving hospital have access to primary care
- Ensuring that homeless people are not discharged to the streets but to emergency or permanent accommodation
- To identify and anticipate the specific needs of homeless people during their hospital admission and discharge and plan accordingly for their care
- To allow earlier discharge for some homeless people by provision of respite beds with intensive primary care and social support
- Increased contact between specialist homeless practice and the most vulnerable homeless people

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

Use the following outline timetable to indicate what impact you expect BCF

schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Work is currently underway to understand this.

Scheme ref no.
16
Scheme name
Enhancing integrated neighbourhood teams
Overview of scheme
This scheme will look to extend and enhance the role of existing Neighbourhood Teams in a range of ways to improve their focus on streamlining discharge and proactively manage patients in the community.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
This business case seeks funding through the Better Care Fund to enhance and sustain a number of initiatives aimed at supporting the overall transformation of adult health and social care and local system change at scale and pace. The overall scheme will look to extend and enhance the role of existing neighbourhood teams in a range of ways to improve their focus on streamlining discharge and proactively managing patients in the community. The enhancement and development of a number of services will ensure that services are best placed to respond to 7 day working as it is further developed across the local health and social care system. This scheme will complement the primary care developments in reducing admission, readmission and act as a stronger “pull” in the system to safely discharge people from hospital and support their return home. The individual proposals as outlined below collectively aim to improve patient experience enable further change on the ground as part of our overall vision for service integration within the city and ensure the system works more effectively to meet demand. The city of Leeds has embarked on an ambitious and challenging programme of transformational change relating to its provision of adult health and social care. The programme of change centres on responding to increasing demand, managing the needs of an ageing population often with one or more long term condition, operating in a climate of reduced resources and responding to what the people of Leeds say about their experience of services to date. Using the Sir John Oldham model of long term condition management an extensive process of consultation and engagement took place across the city to agree and sign off the vision for change. Referred to as the Target Operating Model or TOM, the vision aims to respond to the challenges previously outlined and simplify the model of provision. In essence the TOM identifies a number of components which if successfully delivered would join up and enhance health and social care service provision within Leeds. These are: • Provision of a single gateway or front door to improve access to services across health and social care • Having in place a service that can effectively respond to people in crisis to make safe, maintain in their home with a package of health and social care focused on maximising independence through rehabilitation and reablement. Within our vision this is referred to as the rapid response service

- Working in a joined up way at the neighbourhood level centred on a registered GP practice population. Having the necessary skills within the team to respond effectively to the needs of the population in a proactive way that promotes health and wellbeing and maximises personalisation, choice and self-management supported by the appropriate professionals/agencies. Within this model the ability to provide case management to patients who require it is key as is working with other agencies both statutory and non-statutory within the neighbourhood
- Having an overall ethos/approach that is centred upon maximising people's independence through a model of goal centred intervention that recognises the significant asset the patient/service user bring to the delivery of the plan of care and its success. Equally the approach will focus on maximising independence through enablement focused on keeping the individual in their own home/community wherever possible/appropriate

Significant progress has been delivered over the last 2 years in terms of achievement of the overall vision for integrated services. This has involved considerable clinical engagement to lead, shape and develop the detail of the model to be delivered at the neighbourhood level.
This financial year is seen as a key period in terms of successful delivery of the remaining elements of our agreed vision, supported with an ongoing programme of development to ensure sustainability and delivery of success.
The opportunity to secure additional funding through the Better Care Fund is seen as a significant enabler in terms of adding to plans already in place or about to roll out with the additional money through BCF allowing these plans to go further and thereby have a move significant impact for both patients and the system.

Implementation of Proactive Care models in other areas (e.g. Liverpool, Kent) has demonstrated considerable benefits to patients – especially around the quality of life and ability and confidence to self-care. With regard to the system - reduced hospital admissions, reduced length of stay, reduced use of urgent care and GP/practice nurse appointments and a reduction in avoidable repeat prescriptions.

a) Leeds Equipment Service to be open at weekends – 7 days/week.
The proposal is to maintain the 7 day service that has been operating through the winter period. The seven day a week service will look very similar to the current pilot, with the Store being open 8 till 4 and both a fitter team and an additional driver delivering and collecting essential equipment during this time. Referrals will be taken during opening hours, but only urgent equipment will be delivered/ collected on a weekend, with non-urgent requests waiting until the following Monday. As the store will be open, staff, patients and carers can visit the store during a weekend to pick up or drop off equipment or to discuss any general issues/ problems.

b) Extend hours for the Early Discharge Assessment Team based within A&E, including 7 day working
The proposal is to maintain the enhanced service that has operated successfully over the winter period, including 7 day working. The funding would cover staffing costs across health and social care, including the voluntary sector. The intention is to complete the service review that is currently underway in Q1 in order to maximise service impact and improve robustness of the service. The service enables patients to be diverted to appropriate community alternatives, reducing admissions and enabling proactive responses to patient's needs, returning them to a community setting as soon as possible.

c) Fund additional discharge facilitation roles, including supporting 7 day working.
These roles provide a link between hospital and community services ensuring smooth transfer of care. Through the active case management of patients they support patients who are ready to be discharged. This direct link and strong communication with the wards ensures timely discharge of patients. It will also be developed to provide an educational role with LTHT providing support to explore different alternatives regarding discharge planning e.g. methods of self-management

The proposal is to increase the number of discharge facilitators to 5 WTE to focus on end of life patients and those leaving medicine/elderly wards. This proposal builds on the positive outcomes to date from existing EoL discharge facilitator roles, and the service that was put in place over winter 2013/14.

The existing discharge facilitators have demonstrated clear improvements in the quality of discharge planning for end of life care ensuring a clear link between the district nursing teams and the wards where the patient is being discharged from. The 2 discharge facilitators put in place over the winter have been targeted at the pressured areas supporting patient flow across the system and helping the system to respond when in crisis. They have also focussed on developing operational ways of working with LTHT staff.

This additional capacity will enable the service to provide increased coverage over 7 days.

We will integrate all the discharge facilitators (EOL, A&E, Medicine &Elderly) into one discharge facilitation team over the next few months to ensure a coordinated and efficient service is provided. We will work with LTHT's discharge team to ensure coordinated processes.

The Enhanced Neighbourhood Team proposal will expand capacity in integrated neighbourhood teams in order to work with primary care to:

- proactively manage people to live independently for longer at home, reducing admissions and readmissions
- improve flow from acute settings to reduce length of stay and delayed transfers of care

This will contribute overall to reducing acute activity and costs within the system.

The increased Discharge Facilitators will;

- As identified at the 'whole system discharge' workshop in January 2014, increased capacity to bridge the gap between hospital and community settings will enable more effective joint discharge planning to reduce length of stay and readmission risk.
- Improve the quality of the discharge through a reduction in discharge related incidents
- Improve the patient's experience of their discharge
- Improve the efficiency of the district nursing teams by reducing the amount of time taken post discharge which is currently spent dealing with issues.

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. To develop and deliver a citywide model so that each nominated patient receives a holistic personalised programme of care centred on patient goals which improve the management of their condition, including improving their confidence and ability to self-manage after the programme. This model builds on the good track record achieved to date in IHSC as it supports a more proactive approach that is likely to add greater value for the individual and system. Proactive Care will be one element of Anticipatory Care within the city and will link with the Leeds work on Year of Care tariff. This initiative also supports the Pioneer Bid in enabling the city to go further and faster in terms of impact.

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
The Enhanced Neighbourhood Team proposal will expand capacity in integrated neighbourhood teams in order to work with primary care to:

- proactively manage people to live independently for longer at home, reducing admissions and readmissions
- improve flow from acute settings to reduce length of stay and delayed transfers of care

This will contribute overall to reducing acute activity and costs within the system.

The increase in community nursing capacity will improve 7 day working and flow. It will also provide additional capacity to support and improve end of life care provided by community nursing, recognising the increase in number of people who are choosing to die at home. The need for which is supported by the recent local health needs assessment that was undertaken which identified More people would like to be cared for and die in their own homes.

This increased capacity will also enable the service to better support the earlier discharge of all patients and prevent admissions through proactive management.

g) Retain interface geriatrician role
The proposal is to maintain the existing interface geriatrician support as part of integrated neighbourhood teams, which enables effective clinician to clinician liaison to maintain patients at home and proactively manage patients to prevent avoidable admissions. This will be delivered as an integrated service alongside other community geriatrician input.

The key success factors including an outline of processes, end points and timeframes for delivery

The proposals outlined above will expand capacity in integrated neighbourhood teams to work with primary acre to:

- proactively manage people to live independently for longer at home, reducing admissions and readmissions and
- improve flow from acute settings to reduce length of stay and delayed transfers of care

Overall this will contribute to reducing acute activity and costs.

Some specific examples of how the proposals will do this are:

- 7 day working for LCES will ensure that patients receive the equipment they need at weekends to enable them to stay in their own homes and avoid hospital admission and to facilitate discharge at weekends and throughout the week.
- Implementation of Proactive Care models in other areas (Liverpool, Kent) has demonstrated considerable benefits to patients – especially around quality of life and ability and confidence to self-care, and to the system in terms of reduced hospital admissions, reduced length of stay, reduced use of urgent care and GP/practice nurse appointments and a reduction in avoidable repeat prescriptions.
- End of Life Health Needs Assessment
- Discharge facilitators and enhancing EDAT. As identified at the whole system discharge workshop in January 2014, increased capacity to bridge from hospital to community settings will enable more effective joint discharge planning to reduce length of stay and readmission risk.

BCF National conditions

1. **Plans to be jointly agreed.** The proposals respond to the implementation of the Target Operating Model for integrated adult health and social care services, which has been agreed at multiagency Leeds Transformation Board.
2. **Protection for social care services.** The proposals include funding for health and social care resource as part of integrated working at neighbourhood level and to support discharge planning
3. **7 day services to support discharge and reduce admissions.** As outlined above many of the schemes in this proposal specifically increase capacity at weekends and out of hours to support timely discharge and reduce risk of admission.
4. **Better data sharing between health and social care based on the NHS number the** integrated neighbourhood team model is based around a multi-disciplinary team, including both health and social care, working closely together to deliver a programme of care. The NHS Number has been agreed as the common currency between different organisations. This work is support by ongoing developments in information governance and data sharing between health and social care organisations in Leeds, lined to pioneer status and Leeds Care Record.
5. **Ensuring a joint approach to assessments and care planning and ensure that where funding is used for integrated care there will be an accountable professional**– integrated neighbourhood teams will have a joint multiagency and multi-professional approach to assessment and care planning, including patient and family engagement in this process. This will be supported by a case management approach, including proactive care, and named leads for patients who are being case managed within the integrated neighbourhood teams.
6. **Agreement on the consequential impact of changes in the acute sector.** The proposals outlined are designed to reduce the overall number of acute beds required and reduce length of stay through a more proactive, communit6y based response. The overall impact will be modelled at a programme level.

BCF Performance Targets

1. **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes** – enhancing neighbourhood teams will enable

people to live as independently as possible for as long as possible in their own homes.

2. **Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services**. Effective discharge management and enhancing neighbourhood teams will enable people to live as independently as possible for as long as possible in their own homes.
3. **Delayed transfers of care from hospital per 100,000 population.** The enhanced EDAT and Discharge facilitator capacity will improve flow from acute to community settings reducing DTOC.
4. **Avoidable emergency admissions** – proactive care will improve patients' ability and confidence to self manage their condition. Links with 3rd sector and tele-technologies will support this.
5. **Patient / service user experience** – proactive care will deliver a holistic, patient centric, personalised programme of care based on patient goals. The use of a multidisciplinary team will enhance the perception of a seamless service.
6. **Estimated diagnosis rate for people with dementia** – proactive care will identify patients not currently diagnosed with dementia who are exhibiting early symptoms.

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:

- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

The planned changes in activity are difficult to quantify at this stage. Previous implementation of a proactive care model in Kent showed the following findings based on patients successfully completing the programme. These can be taken as an indicative estimate of the types of results that could be seen in Leeds:

- 15% reduction in A&E attendance,
- 55% reduction in non-elective admissions,
- 37% of cohort had reduced admissions risk,
- EQ5D assessments show 75% of patients reporting improvement in functional quality
- 86% no longer anxious about condition from baseline of 46%
- Current estimate of the number of patients expected to go through the programme in a year is 400-600

Cost impact is difficult to quantify at this stage. Previous implementation of a proactive

care model in Kent showed savings of £1,000 per patient successfully through the programme. This figure is one we aim to replicate in Leeds.

Further work is being done to understand this. However, for 2014/15, as per the benefits spreadsheet, impact is based on a 50 admission reduction from 7 day working by the EDAT team, a 250 admission reduction from case managing 600 patients via the proactive management service, and a 150 admission reduction due to enhance EoL care. The plan is that this programme of work will deliver about a third of its impact in year one, and two thirds in year two.

Scheme ref no.
17
Scheme name
Urgent care
Overview of scheme
This scheme is made up of two elements: "Frequent Flyers": Establish a robust process for managing those identified as frequent users of urgent care services (specifically Out of Hours GPs, Walk in Centres, 999 and Emergency Department attendance, plus others identified by primary care colleagues) to improve patient outcomes and decrease their impact on the wider healthcare system. Utilise portable technology (Abbott i-STAT): to provide point of care blood testing to maximising admission avoidance, speed up discharge from ED and enable enhanced care in community settings.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
The five highest users of ED services at LTHT account for over 500 presentations a month collectively. Some of these presentations will include 999 activity, investigations and admissions to hospital. As well as the explicit impact of high-volume service users there is also the comparatively hidden impact of these users diverting resources away from other service users. Work over winter (led by Local care Direct) suggests that in colder months up to 84 patients/month are referred to LCD out-of-hours for abnormal K+ results when blood tests (taken in-hours) are processed. Of these patients only 3 ended up being admitted, with the other high K+ readings being the result of process errors with the sampling. However all patients have to attend ED (some via ambulance) for repeat tests. This example is a clear indicator of how POCT could reduce ED activity. If this initiative was broadened to provide this facility for other providers (perhaps as part of community care provision, as well as bedside testing in ED to support early discharge/admission decision making) it would facilitate better care across the area
The key success factors including an outline of processes, end points and timeframes for delivery
As already stated the "top 5" attenders at LTHT EDs account for over 500 presentations a month (6000/year) against a 2012/13 ED attendance figure of 190,012 (Leeds Residents only) this equates to an activity reduction of 3.15%. Assuming 250 of these presentations also involve ambulance use (reduction of 3000 calls p/a against activity of 112438 2013/14 projected activity) the reduction equates to 2.67% of activity. No indicative figures are available (at time of writing) for activity reductions in other providers, and it should be noted that these figures only apply if all urgent care

presentations in the top 5 attenders at LTHT are stopped. It is difficult to make activity assumptions as not all activity may be reduced/eliminated and other (lower volume) users have not been factored in.

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:

- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

For the given numbers the maximum reduction in ED activity would be 960 presentations pa (for high K+ only). Without further modelling work it is difficult to estimate the total that could be saved from reduced ED attendances, enhanced ED discharge processes and better community testing supporting enhanced community management pathways.

However, specific focus on case management of top five A&E attenders expected to reduce the emergency admission rate for this cohort by 50% in 2014/15

960 patients represent 0.5% of Leeds patients attending A&E

Scheme ref no.	
18	
Scheme name	
Information technology (inc. social care capital grant)	
Overview of scheme	
This scheme is made up of several Information Management & Technology (IM&T) related projects.	
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)	
Description of Proposal	**Rationale for the proposal**
eCorrespondence implementation Initiative to issue outpatient letters from LTHT electronically and directly into EMIS/TPP GP systems. Funding required to undertake: - Required development of existing WinScribe product. - Testing - Pilot practice rollout - Training and rollout across the remaining GP practices in Leeds - Project delivery resource	- Underpins health and social care integration and the ability to care for patients outside hospital. - Clinical safety improvements by having the information transmitted as soon as available directly into the GP patient record. - Removes the use of fax machines to send outpatient letters if urgent. - Removes the risk of misdirected or lost post. - GP informed earlier if further action required or not which may reduce lead times for treatments and potentially outcomes.
Information Governance (IG) / IG assurance - Dedicated IG coordination resource required to support integration and data sharing initiatives across the city - Funding required to support the coming together of the NHS IG toolkit (IGT) and the IG Statement of Compliance (IGSoC) to establish a single Health and Local Public Services Toolkit	- Improved IG is **mandated as part of the Better Care Fund** - Underpins health and social care integration and the ability to care for patients outside hospital.
Technology to support access to systems in Care Homes GP care in Care Homes not currently supported by a technology provision	- Improved information for clinicians and access to GP IT - systems e.g. SystmOne and EMIS, will support ‘keeping patients out of hospital’.

NHS Number – strategic solution for Social Care Provide a solution to regularly update Social Care systems with NHS numbers. - Capture the technical requirements, design and data standards are required to document the approach in establishing an OpenAPI connection to the Spine Mini services. - Enables Adult Social Care and Children's services to perform real time verification of NHS numbers on their care record systems - System development, integration and testing is required for both systems (ASC and Children) to implement the solution	- Capture and use of NHS Numbers mandated as part of the Better Care Fund - Underpins health and social care integration and the ability to care for patients outside hospital.
NHS Number - Business Change - 'Business change' funding i.e. coordination, to embed the NHS number onto Social Care correspondence for both adult and children's services.	- Full use of the NHS number is mandated as part of the Better Care Fund - Underpins health and social care integration and the ability to care for patients outside hospital.
Leeds Care Record continued development Development of a single system in Leeds that provides access to integrated information. - Resource to manage and deliver the next phase of the project inc: - Integration of adult and children's social care data - Integration of Mental Health data - Expansion of access - Development of requirements to support integrated teams	- Underpins health and social care integration and the ability to care for patients outside hospital. - Supports Increase the number of people supported to live safely in their own home - Example: Increased clinical information from multi-organisations to clinicians will enable better clinical decisions to prevent patients from going in to hospitals and enabling earlier discharge from hospital.
Operational support for the developed Leeds Care Record – - Operational costs and service management required to support	See development bid (above)

this city-wide system. - This would include Help Desk support, on-going licence costs, on-going training, maintenance development, service level management.	
Establishing an N3 connection into the Public Services Network (PSN) Leeds is working towards a single network that will allow staff across health and the city council to access their respective systems using a single network. 1. Establishing a health layer within the PSN to allow health to health data sharing and health to social services 2. Demonstrate the benefits / savings of the aggregated IG regime 3. Establish a regional collaboration layer within PSN to allow access to access services such as voice, video etc. 4. Establishing an N3 connection within PSN to remove the need for organisations to need dedicated N3 connections	- Underpins health and social care integration and the ability to care for patients outside hospital. - Supports the Estates rationalisation work and allows staff to access systems in a unified way from a wide range of public sector buildings. - Supports the technology for purposes such as One Stop Stops.
Programme and Project Management. Business and Benefits Analysis - Programme and project management resources are required to ensure delivery to cost, quality and timescales of the identified (and future) projects linked to the Leeds vision and Integrated Health and Social care. - - Resources are required to undertake key strategic analysis around best use of systems, service improvements and process redesign.	Underpins the delivery of the above work streams
Improved business intelligence – city wide analytical	- Improved commissioning through demand management,

resource - Dedicated and ring-fenced resources to undertake an on-going set of analyses/models to assist with transformational re- design and monitoring. These will be relatively short and medium complexity pieces of modelling work. This will include support to the 5- year strategy.	understanding the cost of pathways and impact of new service provision/design. - Early identification of 'at risk' citizens through Care Trak / Risk Stratification. - Strategic and some financial support to the new Leeds data Mill which will hold non-health, non-identifiable data e.g. transport, crime, utilities - Joint Strategic Needs - Assessment: "We will make decisions based on good information. We all have information about people and places and by looking at this information together; we can make decisions based on a more complete picture of Leeds. We have committed to improve how we collect and use information.
Business Intelligence – - **Leeds data model** The design and development of an analytical 'models' that represents the organisational interactions, data and finance flows across the city to enable the strategic modelling of whole system re-design. This is a medium term/complex piece of work.	See above
Future system/s to support integrated operational services - Likely that the current ASC and Children's and LCH systems will not support strategic care delivery in the future	- Future systems required to support the true integrated delivery/provision. - This may include aligning/integrating/rationalising ASC, LCH and Children's systems. This could include a new procurement.
Reduction in the use of faxes across the city Use of FAX is a poor and insecure way of sharing information for integrated care. Recommendations from the strategic analysis undertaken FY 13/14 included: - Publicity campaign to make staff aware of the alternatives to fax available and the risks and costs associated with using fax	- Supports health and social care integration and improved Information Governance practices. - Provides an evidence trail to clinicians on documentation sent electronically.

machines. - Additional scanners across the neighbourhood teams to support the use of secure mail - Support to implement a fax to email server for LCH buildings (including the neighbourhood teams)	

The key success factors including an outline of processes, end points and timeframes for delivery

Work is currently underway to understand this.

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.

Use the following outline timetable to indicate what impact you expect BCF schemes to have by:

- **April 2016**
- **April 2017**
- **April 2019 (three years after 2015/16)**
- **April 2021 (five years after 2015/16)**

- Improved GP response time to outpatient letters
- Confidence that data/ information used within the Law
- Improved care and clinical decisions
- Improved identification of patients in related services
- Fewer repeated questions / tests.
- Increased personalised care.
- Electronic, up to date information removing reliance on paper
- Improved commissioning and planning decisions
- Faster, more accurate and more secure transfer of information.

Scheme ref no.
19
Scheme name
Care Bill
Overview of scheme
Work is currently underway to fully understand the impact of the Care Act in Leeds and as such we are not able to complete a full business case at this stage.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
Leeds has initiated a programme of work for implementing the Care Act (2014). The Programme consists of several projects which focus on delivering the different aspects of the Act overseen by a Programme Board chaired by the Deputy Director of Adult Social Care. The programme consists of work with a broad range of stakeholders to: understand and model the impact of the Act; the draft guidance and develop options for how the new duties could be met. It has identified the key priority areas as: 1. Carers; 2. assessment and eligibility; 3. IM&T as an enabler; 4. Information and advice. The option appraisals will identify the most effective and efficient way of meeting the increased assessment and service delivery responsibilities under the Act. This will involve a comprehensive piece of work on demand and capacity planning, particularly as it relates to carers, assessment and eligibility and self-funder. It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for September. Following this phase of the programme and the options presented, Leeds will take a final decision on how best the new duties will be met. Alongside this work is a Consultation, Engagement and Communication Strategy to ensure that there is effective engagement with stakeholders including service users
The key success factors including an outline of processes, end points and timeframes for delivery
TBC Options appraisal and modelling to be undertaken prior to October ‘14. Decisions on future models to be made in October ’14.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
All of our schemes in Leeds have been developed in close collaboration with colleagues from the CCGs and Local Authority to ensure alignment across the system. The schemes have been approved by our local Health and Wellbeing Board and developed through our Integrated Commissioning Executive and Transformation Board. Objectives

of the BCF plan and its individual schemes have been developed in relation to our JHWS which was informed by our JSNA.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
Work is currently underway to understand this.

Scheme ref no.
20
Scheme name
Improved system intelligence
Overview of scheme
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.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
Clinical audit is a well-established quality improvement process that seeks to improve patient care and outcomes through systematic review of care. It is our assumption that by carrying out this audit with those admitted to hospital, we can better understand patient experience, barriers to using community-based care and gain some behavioural insight. Whilst this is not an outcome in its own right, it will allow us to better commission services and design programmes that meet patient need. Thus, it is an important scheme to help us develop the detail of our BCF plans and ultimately reduce demand on the acute sector by enabling better use of community services.
The key success factors including an outline of processes, end points and timeframes for delivery
Project plan in development.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
The findings as a result of this audit will inform the refresh of the JSNA, strengthening the data pack around integrated care and providing care closer to home – this, in turn, aligns to the JHWBS. The audit is expressly designed to inform CCG commissioning plans for 2015/16 and beyond.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
April 2016 - results of audit will have informed more detailed, precise commissioning plans which will have been tested out in 15/16 April 2017 – 2nd year of commissioning plans informed by results of audit seen in service provision April 2019 and April 2021 – contribution to overall system reduction in reduce in demand on the acute sector as barriers to using community services/more appropriate community services established

Scheme ref no.
21
Scheme name
Workforce
Overview of scheme
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.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
The need to tackle workforce development is clearly documented when it comes to transformational change to bring about truly integrated care and shape the health and care landscape to be fit for the future - http://www.cfwi.org.uk/. This is also evidenced by the integration pioneers – it is a key work stream for Pioneers and support partners to address collaboratively. There is a limited evidence base for how best to go about making these changes, so this scheme will contribute to growing this and examine what is already in existence.
The key success factors including an outline of processes, end points and timeframes for delivery
The workforce development group of the Transformation Programme is established and will oversee this piece of work. Key processes include: - setting out the scope of the project - evaluating the existing evidence base - working with the Leeds Pioneer programme to link in with Health Education England, Skills for Care and Skills for Health - Leeds approach and strategy developed Exact project plan details still in development.
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
Workforce development is an enabling group of Leeds' transformation programme.
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
April 2016 – workforce development strategy agreed and published April 2017 onwards – roll out of strategy implementation April 2021 – work underway to understand this in line with broader transformation programme.

Scheme ref no.
22
Scheme name
Contingency
Overview of scheme
This is the Leeds BCF contingency provision, arrived at following a risk base assessment. Funds here will also be used to fund schemes in 15/16 that are being worked up during 14/15 that will deliver savings.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
Contingency – in the event that Leeds fails to deliver anticipated savings through its BCF schemes, will ensure service provision can continue to meet patient demand. 15/16 schemes – enable us to implement schemes that are being worked up / scoped in 2014/15 which will contribute towards national outcomes.
The key success factors including an outline of processes, end points and timeframes for delivery
Not applicable
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
All proposed BCF schemes upon which contingency funding will be spent align to system priorities and plans in the city
Use the following outline timetable to indicate what impact you expect BCF schemes to have by: • **April 2016** • **April 2017** • **April 2019 (three years after 2015/16)** • **April 2021 (five years after 2015/16)**
If contingency funding can be used to support schemes being worked up in detail, impact will be linked to those schemes.

[ANNEX 2 – Provider commentary]

Name of CCG	Leads South and East CCG, on behalf of Leeds West CCG and Leeds North CCG
Name of CCG Accountable Officer	Matt Ward, Chief Operating Officer, Leeds South and East CCG
Signature (electronic or typed)	
Name of Provider organisation	Leeds Teaching Hospital NHS Trust
Name of Provider CEO	Julian Hartley
Signature (electronic or typed)	

For CCG to populate:

Total number of non-elective FFCEs in general & acute **[see E.C.4 of planning guidance]**	**2013/14 Outturn**	66,265
	2014/15 Plan	66,118
	2015/16 Plan	64,911
	14/15 Change compared to 13/14 outturn	-147
	15/16 Change compared to planned 14/15 outturn	-1,208
	How many non-elective admissions for the CCG is the BCF planned to prevent in 14-15?	680*
	How many non-elective admissions for the CCG is the BCF planned to prevent in 15-16?	590

***demographic pressure is expected to increase non-elective admissions by 1,240 admissions during FY14/15. BCF will impact the gross position, leaving a gap between the BCF and submitted plans of 674 admissions for FY14/15.**

For Provider to populate:

	Question	Response
1.	**Do you recognise the planned non-elective (general and acute) admissions data for 14/15 and 15/16 submitted by the CCG?**	The planned activity submitted by the CCGs is consistent with overall trajectory anticipated. This activity was shared with Leeds THT in advance of submission.

2.	**Do you agree with the data submitted for the impact of the BCF in terms of planned in non-elective (general and acute) admissions 15/16 compared to 13/14 outturn and planned 14/15 outturn?**	It is not possible to confirm this at present. The overall quantum of change is in line with previous agreements, but scheme development is not yet sufficiently progressed to quantify the impact of each individually.
3.	**If you answered 'no' to Q.2 above, please explain why you do not agree?**	
4.	**Can you confirm that you have considered the resultant implications on your organisation?**	Leeds THT understands the overall objective and impact of the BCF programme and recognises it as an important component in achieving financial sustainability for LTHT and the Leeds health and social care economy. However, we have not yet modelled clinical strategy at a sufficiently granular level to determine the precise implications. This work will take place over the next 6 months as clinical business strategies are developed.