SCHEME NAME :- REABLEMENT	
SCHEME NO	**01**
RESPONSIBLE GROUP	**Better Lives Through Integrated Services**
ACCOUNTABLE LEAD OFFICER	**Dennis Holmes – Michele Tynan / Paul Morrin**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	**V0.3, 18/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Reablement of service users to allow them greater independence to remain in a home environment for longer.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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 turn report through the Transformation Board and link to the Health and well Being Board.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

At the time of writing, the Leeds reablement service runs at a comparatively low volume of throughput. The service however is efficiently run and well managed – the service has consistently achieved the target 90% of patients going through the service not needing hospital treatment within 91 days.

Our plans for the service in Leeds is to maintain this strong performance, but to increase the throughput of the service.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 4,512 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

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.

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.

Due to lack of available beds, it is estimated that 420 patients who could have been diverted from A&E into a CIC bed end up being admitted to hospital non-electively each year. By adding capacity to the system and re-designing the pathway this initiative is anticipated to avoid these admissions.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of*

the proposal to your overall objectives?
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME
- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

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.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

This is an established service and any risks are currently being managed through the Better Lives Through Integrated Board and the Service Delivery Group for Reablement.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*

- *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- Community Beds	
SCHEME NO	**02**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan / Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

£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 DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- To support the selection and design of this scheme
- To drive assumption about impact and outcomes.
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The existing community bed estate will be used more efficiently and will be changes so that it accepts patients with a wider range of needs, increasing the throughput of patients in the service.

INVESTMENT REQUIRED

- Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

£5,300,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- Identify the key stakeholders and the impact of the proposal on them?
- Reduce activity (whole system/specific)
- Reduce cost (whole system/specific)
- Improve patient experience.
- Impact BCF metrics (BCF national conditions / performance targets)
- Other locally important measures or metrics.
- What Research and evidence have you consulted to generate a set of assumptions about future outcomes?

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

'Small impact on admissions may be expected as rehabilitation services are more widely available,expectation is reduction in 10 admissions.

'Stream-lining bed provision to more generic beds that can accept patients with a wider range of needs is expected to increase through-put, allowing more patients to access the service (estimated to be 5 fewer patients awaiting a CIC bed which equates to 1,825 fewer bed days lost due to DToC)

'Improved use of Community Intermediate Care (CIC) beds allows more patients to be transferred direct to a CIC bed, avoiding A&E attendances/hospital admission. Planned work to deliver internal efficiencies are expected to free up five beds to manage new community referrals, allowing 73 non-elective admissions per year to be avoided. This is predicated on increased community-referrals (where the patient would otherwise have been admitted to hospital).

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- What is your approach to measure the impact of this proposal?
- What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?
- Can you set up a counterfactual or control?
- Will data be generated automatically or does it require a new survey / data collection approach?

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an “Outcomes Based Accountability” (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- E.g. expertise, staff, demographics, history of partnership working.
- Do these also exist within the local area?
- If not – have actions been put in place to resolve this?
- OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?
- An outline of a stepped approach to implementation which draws on
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

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.

KEY RISKS

- To the success of the proposal

- To other parts of the system as a whole (i.e. potentially unintended consequences)
Risks will be managed through the local community bed group.
PROPOSAL IMPLEMENTATION PLAN - Start date - End date - List of key deliverables and the dates associated. - Outline roles and responsibilities for delivery and implementation of the proposal.
Small impact during 2014/15 with continued implementation during 2015/16.

SCHEME NAME :- Supporting Carers	
SCHEME NO	**03**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Matt Ward**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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 DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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)

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The funding for this scheme is recurrent monies and we do not expect this scheme to have an impact over and above the current baseline performance.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,059,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about*

future outcomes?

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

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and

ii) engagement with partners about the deliverability of the proposal
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
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
This will be managed through the local carers strategy group
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015/16

SCHEME NAME :- Equipment Service	
SCHEME NO	**04**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

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

OVERVIEW OF THE SCHEME --- *point 1 from the old format*
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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

THE EVIDENCE BASE--- *point 2, 3 from the old format*
Please reference the evidence base which you have drawn on,

- To support the selection and design of this scheme
- To drive assumption about impact and outcomes.
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Moving the service to a 7 day a week service, and broadening the range of technologies available, will support people to continue to live in their own homes and support quicker discharge and reduced delayed transfers of care.

INVESTMENT REQUIRED --- *point 5 from the old format*

- Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

£2,300,000

IMPACT OF THE SCHEME *--- point 4, 6, 7 & 10 from the old format*

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- Identify the key stakeholders and the impact of the proposal on them?
- Reduce activity (whole system/specific)
- Reduce cost (whole system/specific)
- Improve patient experience.
- Impact BCF metrics (BCF national conditions / performance targets)
- Other locally important measures or metrics.
- What Research and evidence have you consulted to generate a set of assumptions about future outcomes?

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 evaluations 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%

2016 5% reduction in LOS
2017 5% Reduction in LOS
2019 10% reduction in LOS
2021 10% reduction in LOS

On average around 500 bed days are lost per year due to delays associated with community equipment. It is estimated 25 of these may be avoided through the adoption of smarter technologies, but this is difficult to quantify

'Current plans propose extending existing service offer to include new technologies that enable more complex patients to be cared for at home, reducing admissions by 6.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- What is your approach to measure the impact of this proposal?
- What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?
- Can you set up a counterfactual or control?
- Will data be generated automatically or does it require a new survey / data collection approach?

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in

the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- E.g. expertise, staff, demographics, history of partnership working.
- Do these also exist within the local area?
- If not – have actions been put in place to resolve this?
- OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?
- An outline of a stepped approach to implementation which draws on
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- 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.

KEY RISKS --- *point 8 & 9 from the old format*

- To the success of the proposal
- To other parts of the system as a whole (i.e. potentially unintended consequences)

PROPOSAL IMPLEMENTATION PLAN

- Start date
- End date
- List of key deliverables and the dates associated.

- Outline roles and responsibilities for delivery and implementation of the proposal.
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

SCHEME NAME :- Third Sector Prevention	
SCHEME NO	**05**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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 DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This is a recurrent scheme and we do not expect that it will have a benefit over and above the current set of Leeds baseline performance against the BCF metrics.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 4,609, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*

- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

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

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and

ii) engagement with partners about the deliverability of the proposal

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

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Joint adult commissioning group

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

April 2015

SCHEME NAME :- Admission Avoidance within LTHT	
SCHEME NO	**06**
RESPONSIBLE GROUP	**Joint Adults Commissioning Group**
ACCOUNTABLE LEAD OFFICER	**Sandie Keene / Phil Corrigan**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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 DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This scheme is closely linked to both the Admission and Discharge Group, the Transformation Board and the H&WBB.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*

- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This funding is an existing allocation of money, and we do not expect it to contribute to the Leeds performance over and above the baseline position.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,800, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Further work is currently underway to fully assess the impact.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection*

approach?

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Further work is currently underway to fully assess this.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

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.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*

- *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- Community Matron	
SCHEME NO	**07**
RESPONSIBLE GROUP	TBC Brian Collier (Transformation Director) Mark Hindmarsh (interim project manager)
ACCOUNTABLE LEAD OFFICER	Andy Harris/Ian Cameron
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

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 DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

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.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,683, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Impact still being reviewed in light of scheme 16.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- 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

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

This will be managed by the joint adult commissioning group.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*

- *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2014

SCHEME NAME :- **Social care to benefit health**	
SCHEME NO	**08**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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	'There was an overall continued reduction in permanent care home admissions of people over 65 during 2013/14 and indicative data for 2014/15 suggest that admissions remain low. Placement Approval Panel data shows that there have been 68 fewer placements approved between April and September, and 63 fewer coming from hospital, compared with the same period last 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 DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This is the NHS England transfer from health to social care and will be used to fund existing schemes. This is a recurrent scheme and we do not expect that it will have a benefit over and above the current set of Leeds baseline performance against the BCF metrics.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 12,417k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

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.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The details for each of the components of this scheme are currently being developed.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Will be managed through the Joint Adult Commissioning Group

PROPOSAL IMPLEMENTATION PLAN

- *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- Disabilities facilities grants – Rob McCartney providing more info	
SCHEME NO	**09**
RESPONSIBLE GROUP	
ACCOUNTABLE LEAD OFFICER	**Bridget Emery**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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 DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*

- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,958, 000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

This is a recurrent scheme and we do not expect that it will have a benefit over and above the current set of Leeds baseline performance against the BCF metrics.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*

- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Work is currently underway to understand this.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

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.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

April 2016

SCHEME NAME :- Social Care Capital Grant - Care Act (2014)	
SCHEME NO	**10**
RESPONSIBLE GROUP	Care Act Programme Board
ACCOUNTABLE LEAD OFFICER	Sukhdev Dosanjh, Chief Officer Social Care Reform, ASC
BUSINESS CASE AUTHOR/S	Jason Beavors
VERSION & DATE	**Ver** : 0.1 (Draft) **Date** : 10/09/2014

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

The Care Act 2014, which has been described as the most significant change to the care and support system in over 60 years, places new statutory duties on Leeds City Council from 1st April 2015.

In addition to the statutory duty the Care Act brings to the authority, a clear strategic vision for health and social care has been set out in the 'Department of Health's Information Strategy' which is fully aligned to the Government's IT strategy and 'digital by default' agenda. Leeds, as a city, has a successful integration programme in place with our Health partners to deliver part of this strategy. However, there are some ambitions set out by the Secretary of State that need to be supported by the modernisation of services. The key ones relevant to this paper are :

- Transactions – focusing on the modernisation of services to bring the system up to the standards people expect in today's online society
- Reduced administrative burden – reducing the time front line services spend on administering systems and complying with data requirements

To enable the Council to successfully fulfil the additional duties and deliver the vision will require significant change to information management and technology systems. Without the investment required to implement these technology changes, the Council will not be able to deliver the requirements of the Act and maintain the current quality of services currently provided to the citizens of Leeds. This is due to the anticipated rise in demand for assessments, care and support services, and information as a result of the implementation of the Act.

Leeds City Council Adult Social Care is working at a regional and national level with a number of external partners and stakeholders to identify opportunities to provide care services in innovative and cost effective ways. This has been recognised by the selection of Leeds to be assigned pioneer status to assist in enabling the city to go 'further and faster' to ensure children and adults experience high quality and seamless care. The development of modern online solutions as part of the Care Act implementation will provide a platform upon which to progress some of these potential initiatives such as self-management of health and social care. Please note that the funding for these initiatives is not included in this paper.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:
- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*

- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

It is anticipated that the Care Act 2014 will bring a rise in demand for assessments, care services and information. This is in addition to new requirements such as the care cap and the provision of care accounts to monitor progress towards the cap.

The Council is currently developing and implementing a new Case Management System (CIS) and earlier known requirements for the Care Act have been included in this design. However, the CIS system is only a component of the overall technology required to enable the Council to deliver the Care Act.

To enable the Council to meet the anticipated increased demand and new duties, it is proposed to develop self service solutions including online options for self-assessment, online requests for service, online review of personal care accounts, online access to care assessments, etc. To deliver these online services will require investment in the development of electronic forms, interfaces between multiple systems to enable citizen access to consolidated personal information, links to external data sources to increase the breadth and consistency of advice and information, and the introduction of electronic methods of data transfer of care information between authorities.

Another advantage of developing these online options is the flexibility of access this will provide service users, carers, and other people involved in their support and wellbeing, to be able self-serve as much as possible.

The outputs of this workstream will be available to all citizens who need to access care services, or any advice, guidance and information associated with its provision.

The introduction of the Care Act in April 2015 places new statutory duties on Leeds City Council. Adult Social Care has included some of the known changes within the new client and case management system but this is only a single part of the solution. As a collective, the current information management and technology systems within Adult Social Care do not currently have the capability, or capacity, to enable the Council to meet the statutory duties placed on it by the Care Act. The key requirements identified as part of a review of preliminary guidance from Association of Directors of Adult Social Services Information Management Group (ADASS IMG) include :

- Systems need to be capable of scaling up to meet the potential increased demand for assessments
- Systems need to enable the recording of non-eligible needs, as well as eligible needs
- Provision of a compliant financial assessment system for service users and carers
- Provision of a care account for citizens to enable them to monitor progress towards the newly imposed care cap
- Provide citizens with a record of assessments and care plans. This could be written or electronic
- Implement workflow functionality to prompt review of care plans
- Implement interfaces that enable the transfer of key information such as care accounts, assessments and care plans between Local Authorities should citizens relocate
- Implement new ways of working for social care workers including the capture of information at point of contact with the service user or carer
- Ensure all systems have the citizens NHS number and that all correspondence includes this

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

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.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The Council has a statutory obligation to ensure compliance with the requirements of the Care Act 2014.

The impact and outcomes of the implementation of the Care Act 2014, based upon analysis of current information and knowledge, supports the view that there will be increase in the demand for care services and information. When this increased demand comes to fruition it will not be possible to continue to provide the current quality range of services via existing resources and business models. It will be necessary to provide an improved information offering and a range of online services to enable self-service as an option.

The benefits associated with this project are around cost avoidance to enable the continued delivery of quality services and information to a larger cohort of citizens within existing resource levels, supported by modern technology solutions expected by todays online society

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

The investment requested from the Better Care Fund 2015/16 is £ 744,000

This is part of an overall investment plan approved by the Councils Executive Board on the 16th July

2014 :

- £744k Better Care Fund
- £608k Capital Funding
- £300k from existing Case Management implementation project

Total : £1,652k

The estimated breakdown of this spend is :

- £0k - for essential changes to the CIS system as these are included in partnership maintenance
- £50k - Leeds only CIS developments
- £60k - IT hardware infrastructure
- £20k - External security testing of implementations
- £220k - e-form developments
- £1,302k – for resources (incl. Project Management, ICT Technical, Systems Analysis) to design and develop the following :
    - Improve and expand web content with feeds from external sources
    - Develop interfaces between multiple systems to provide consolidated view of customers care transactions
    - Develop and implement national standards and interfaces to transfer care information to other authorities.
    - Develop systems to enable the capture and management of new information requirements such as care accounts.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The key stakeholders of this proposal are :

- all people associated with the assessment and delivery of Care services within Leeds
- all citizens of Leeds who have a need to understand how Care services are provided in the Leeds, the support and options available, and how to access these.

As described earlier, the main focus of this project is to enable the continued delivery of quality of services within challenging budget parameters. It will also provide citizens with services via methids expected in a modern online society.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

As part of the implementation of the technology solutions, key reporting requirements to measure the impact and success of this project will be developed. This will enable the automatic generation of statistical data such service provision numbers, etc.

There are also existing consultation groups that will be utilised to ensure continued dialogue and engagement in the development and implementation of technology, processes and solutions that meet the needs of the citizens.

By utilizing the above 2 approaches, we will ensure that we have both factual based evidence and stakeholder input to understand the impact of the changes and enable us to build on the successes and address areas of weakness.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The key success factors for the implementation of this scheme are :

- The provision of Care services to the citizens of Leeds remains of high quality and continues to be delivered within existing resources and budgets
- The citizens of Leeds and all people involved with the provision of Care services successfully adopt the digital solutions available

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

The key risks to this proposal are :

- Citizens do not utilize the digital options and continue to request traditional resource intensive methods of service delivery
- Staff do not embrace and support the implementation of this change
- Time between publication of Care Act guidance and implementation deadlines
- There is already a significant amount of change being embarked upon within Social Care which is utilising key resources. This project will be requesting support and assistance from

already fully committed resources.

- This project has a dependency on the implementation of the Customer Contact Portal which is in the scope of the Councils Customer Access Programme. Failure or delays in the delivery of this will impact on this project.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Preparation and start up phase of the project commenced in June 2014.

The implementation is planned in 3 phases :

- Phase 1– April 2015 – This phase will implement the technology solutions to deliver the fundamental changes to assessments and eligibility criteria, and support the delivery of increased demand.

- Phase 2 Go-live – October 2015 – The key launch in this phase will be care accounts to prepare for the introduction of the care cap in April 2016.

- Phase 3 Go-live – April 2016 – The key launch in this phase is the care cap, and the technology solutions that will support the provision of this.

SCHEME NAME :- Enhancing primary care	
SCHEME NO	**11**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Gordon Sinclair**
BUSINESS CASE AUTHOR/S	**Kirsty Turner, Gina Davy, Sue Jones/Deborah McCartney**
VERSION & DATE	**V4 17/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME:
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

We want frail older people and other patients with complex needs to be cared for and well managed at home, where clinically appropriate, and to experience an improvement in the quality of care received.

Services that deliver these outcomes for frail older people and patients with complex needs should deliver a range of benefits that patients have told us are important. We believe our member practices are best placed to identify the specific practice and locality level services and interventions to achieve these outcomes and patient benefits.

From 2014/15 the 'Proactive care programme' element of the GP contract incentivises General Practice to take a case management approach to the top 2% high risk and vulnerable patients on their practice registers. Simultaneously, NHS England's 2014/15 planning guidance, 'Everyone Counts', set out an expectation that CCGs should commission services to improve care for frail older people and those with complex needs. We think that these complementary commissioning requirements provide a huge opportunity for the Leeds CCGs to work together with member practices to commission locally appropriate primary and community services which ensure our older populations and those with the most complex needs and cared for and well managed at home, where possible and clinically appropriate.

The specific objectives of the scheme are to:

- support and enable further integration of health and social care working around the needs of the patient.
- ensure people are cared for and well managed at home and therefore reduce the number of emergency admissions to hospital.
- improve the quality of care for frail older people and people with complex needs.
- support and maximise the delivery of the Proactive Care Programme.
- strengthen primary care for a move of services from secondary care into the community.
- support collaborative working and learning between member practices and CCGs.
- identify learning and best practice to share across the CCG and city.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

We have worked closely with member practices to understand what *additional*primary and community care will enable delivery of pro-active care for our local populations of older people and those with complex needs, that is both effective and outcome drive. Based on this clinically led engagement, CCG localities have identified the specific interventions that they feel will have the greatest impact on supporting frail older people and those with complex needs.

As CCGs, we have each commissioned additional primary and community schemes to support older people and those with complex need in 2014/15. Working together, we will test, evaluate and refine the range of interventions commissioned through our respective 2014/15 schemes to help inform the range of primary care interventions we commission as part of this 2015/16 Enhancing Primary Care Scheme.

The specific interventions, service change and new ways of working to be commissioned through this Enhancing Primary Care Scheme will vary by General Practice/locality and commissioning CCG. Examples may include:

- commissioning general practice to provide primary care based clinical care coordinator roles to deliver effective care and case management.
- commissioning general practice and other providers to provide additional multidisciplinary primary care clinics for the proactive care of local practice populations with specific complex needs.
- commissioninggeneral practice and other providers to provide additional primary care capacity to provide more in-depth and joint consultations with patients, carers and/or members of Integrated Neighbourhood Teams.
- commissioningLeeds Community Healthcare to provide additional capacity within Integrated Neighbourhood teams to enhance integrated support across primary care, community care and third sector within specific localities.

Depending upon the intervention commissioned, the scheme will be delivered by members of primary care, community services, voluntary and community and faith sector groups in a variety of venues which may include patients' homes, general practice and community venues.

The interventions we put in place willdesigned to explicitly support, complement and enhance the Proactive Care Programme. At the time of writing, we are exploring how we could potentially work with NHS England to locally shape the 2015/16 Proactive Care Programme alongside the Enhancing Primary Care Scheme to align and integrate these work streams as part of our broader co-commissioning agenda.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The Enhancing Primary Care Scheme will be commissioned by Leeds North CCG, Leeds South and East CCG and Leeds West CCG through clinically-led commissioning processes and engagement with member practices.

The interventions being commissioned through the scheme are likely to be provided predominantly by general practices working closely with Integrated Neighbourhood Teams, community services and local Voluntary, Community and Faith Sector Groups. In some cases interventions may also be commissioned directly from Community services and Voluntary, Community and Faith sector groups.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence youhave consulted to plan your approach to integrated care overall]*

There is a requirement nationally that CCGs will provide additional investment to support improving the care to patients aged 75 or older. The 2014/15 Planning Guidance "Everyone Counts – Planning for Patients 2014/15-2018/19" states:

"CCGs will be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice, which broadly equates to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund. "

Guidance contained within Publications Gateway Reference 01414 "A Programme of Action for General Practice" stated that;

"CCGs should be using this funding to commission additional primary care services or community health services (over and above those provided under the new enhanced service) that you and other practices in your area have prioritised. It is important that you work closely with your CCG to make the best use of this £5 per patient. Any practice plans should complement the initiatives planned through the Better Care Fund for 2015/16, for which one of the criteria is an accountable professional for integrated packages of care".

In 2014/15 each CCG has commissioned additional primary and community schemes to support older people and those with complex need in 2014 to the value of £2.64 per head of registered general practice population. This complements additional clinical commissioning schemes commissioned from general practice at £2.36 per head of registered population to make up the nationally required £5 per patient stated above.

The primary and community schemes we have commissioned (using the £2.64) in 2014/15 to support older people and those with complex needs have been developed through extensive engagement with our member practices and in response to key themes and priorities identified through service user and carer engagement at CCG and citywide level. Service user and carer engagement has identified a range of patient-level outcomes that the initiatives commissioned through the Enhancing Primary care Scheme aim to achieve. These are that patients:

- have one contact person (care co-ordinator/named GP) totake a lead in making sure care plans are followed and care is delivered
- don't have to see as many professionals and repeat their story
- who may need admitting to hospital have a reduced length of stay and are seen swiftly
- feel better supported and are able to meet the demands of their caring role
- who are isolated have wider support put in place through the 3rd sector
- feel confident in managing their care if an exacerbation occurs
- know who to contact and what is happening next in their care
- feeling listened to and well supported

The evaluation of the primary and community interventions we have commissioned (using the £2.64) in 2014/15 will be central in determining the initiatives to be commissioned through the 2015/16 Enhancing Primary Care Scheme. The metrics being used to evaluate each of the interventions being commissioned in 2014/15 vary considerably by intervention being made. However, in planning and monitoring evaluations, practices are encouraged to work as a locality to share planned approaches, learning and emerging results.

Over the course of 2014/15, as CCGs, we will track system-wide BCF indicators at CCG level. The three Leeds CCGs will collectively measure these indicators to understand progress towards these across the CCGs. These are:

- patient / service user experience
- avoidable emergency admissions

It is recognised that it is not possible to attribute a causal relationship between practice-level interventions and the system-wide BCF indicators that the CCG will collect. However it is anticipated that the initiatives and services commissioned in 2014/15 will contribute, alongside the Proactive Care Programme Approach and other initiatives, to the system-wide BCF indicatorsand supplementary measures have been developed to track this contribution.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£ 2,141, 000 as calculated by £2.64 per head of CCG registered population. Breakdown as follows:

Leeds North CCG £545,136
Leeds South and East CCG £678,480
Leeds West CCG £924,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Through the Enhancing Primary Care Scheme primary and community services will be commissioned to deliver services and interventions to achieve the following outcomes:

1) to ensure frail older people and/or those with complex needs are cared for and well managed at home where clinically appropriate.
2) to ensure frail older people and/or those with complex needs experience an improvement in the quality of care they receive.

In turn, it is anticipated that these will contribute to the following citywide system indicators and overall achievement of the following overarching outcome of the Better Care Fund:

- improved patient/service user experience
- reduction in avoidable emergency admissions

The relationship between the Enhancing Primary Care Scheme the contribution to citywide indicators is demonstrated in the diagram below. As CCGs, we will assess whether Leeds as a health and social care system is making progress towards achievement of the system and BCF outcome as quantified through the citywide indicators below. It is not possible to attribute a direct causal link between individual practice-level interventions and the achievement of citywide indicators. Practices will however be required to use information and data to evaluate the extent to which the planned intervention or service have delivered the contribution which they set out to make – please see Figure 1

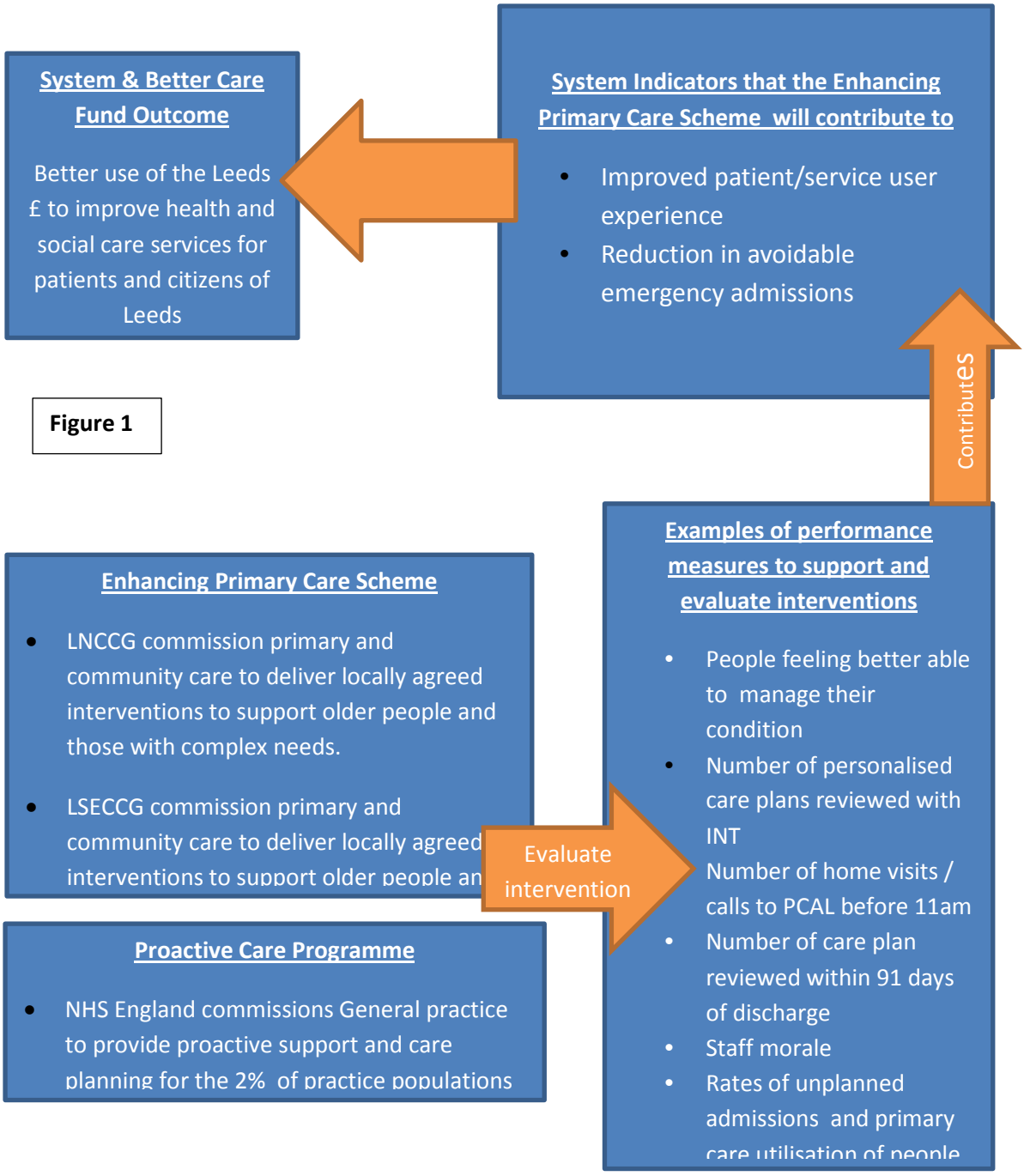


Figure 1

As previously stated, the evaluation of the primary and community interventions we have commissioned (using the £2.64) in 2014/15 will be central in determining the initiatives to be commissioned through the 2015/16 Enhancing Primary Care Scheme. As these interventions are only just commencing, and yet to be evaluated, it is not yet possible to anticipate the impact on local performance measures or the contributory impact on the system indicators of improved patient experience and reduction in avoidance emergency admissions.

In the absence this information, based on modelling undertaken by Dr Tom Mason, it can be assumed that this scheme will support primary care to put in place care plans for their top 2%

populations, the benefit being that by going through this process the unplanned hospitalisation risk for these patients will fall be between 5 and 10 %. This is a relatively conservative assumption that translates into around 1,000 avoided admissions to hospital each year across the city.

Assuming the vast majority of patients being managed under the scheme are 65 and over, the reductions in admissions may be expected to reduce the total number of elderly patients being admitted to hospital by between 1.3 and 3.5% (based on the success of the scheme). Assuming a one-to-one relationship between admissions and DToC, this translates into DToC of between 240 and 640 lost bed days per year.

Through the interventions commissioned through the Enhancing Primary Care scheme, we aim to have an impact on reducing emergency admissions through the effective and pro-active case management and ensuring that admissions are avoided through care planning.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Each intervention commissioned through the Enhancing Primary Care Scheme will establish arrange of performance measures to measure the impact of the given intervention. Performance measures will vary by intervention but may include:

Patient performance measures:

- Patient reported ability to manage their own health
- More effective/ reduced duplication in visits from members of Integrated Neighbourhood team/GP Practice
- More comprehensive care plan, supported by VCF sector organisations

Practitioner performance measures

- Reported improvement in working relationships across primary care and Integrated Neighbourhood Teams
- Staff morale

System measures

- Patients better supported by VCF sector
- Attendance and input of Integrated neighbourhood team in case management meetings
- Number of emergency admissions and readmissions

To enable comparability across different interventions commissioned, all interventions will utilise patients experience measures and also measure the number of emergency admissions across the patient cohorts supported through the given intervention.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*

- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Work is currently underway to understand this.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Risk	Mitigation.
Workforce; There is a risk that the appropriate workforce is available with specific skills	The interventions commissioned in 2014/15 (which will inform which interventions are commissioned in 2015/16) have been developed and discussed in partnership with general practices and Leeds Community Healthcare thus reducing the development of interventions based on a non-existent workforce.
Delay in implementation; There is a risk that the time taken to establish interventions commissioned in 2014/15 will result in a paucity of performance measures to determine which intervention have had the greatest success.	Consideration of the the continuation of interventions commissioned in 14/15 into 15/16 to establish sufficient information to enable appropriate evaluation of individual interventions.
Links to other providers; LCH/ASC may have already developed their plans (as part of the BCF) and General Practice may be excluded	The CCG is actively engaged in the LCH CQUIN Implementation Group and is ensuring that primary care is appropriately represented to ensure that all plans support integration.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

TBC

SCHEME NAME :- Redesign of dementia pathway and creating "Eldercare Facilitator" role	
SCHEME NO	**12**
RESPONSIBLE GROUP	**Tim Sanders with** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris / Ian Cameron – LTC**
BUSINESS CASE AUTHOR/S	**Tim Sanders**
VERSION & DATE	**9th September 2014 – v2**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Leeds dementia strategy objectives:

More people with dementia will be diagnosed, at earlier stages of the condition, and this will lead to better support and quality of life.

People living with dementia alongside other health conditions and disabilities, will have integrated support to maintain emotional, psychological and physical well-being.

To create holistic management of dementia and comorbid physical and mental health conditions; and provide early support to promote well-being and independence (National Dementia Strategy, NICE clinical guideline). Improve quality of life with dementia (NHS Outcomes Framework 2.6ii / Adult Social Care Outcomes Framework 2F).

To bring memory assessment, diagnosis and management of dementia into the GP practice setting, to improve access and reduce stigma associated with the condition; whilst maintaining the role of specialist clinicians in memory assessment and diagnosis, and ensuring ready post-diagnosis access to specialist services as required in response to need.

Create the role of "eldercare facilitator"[1], one FTE for each of the 13 neighbourhoods, to work as part of primary care team, providing post-diagnosis follow-up. The role could be provided by third sector or an NHS provider, and will require 'honorary contracts' to work effectively within practices and share information.

To design a "Year of Care" holistic review process for people living with dementia, including any medication monitoring once prescribing is initiated and stable. This would remove duplication between memory service review and GP QOF review; focus on support for the person to live well, rather than cognitive test scores.

To sustain and accelerate the trend of improvement in dementia diagnosis rate (NHS Outcomes Framework 2.6i).

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*

[1] This job title is used for a similar role developed by Dr Ian Greaves and colleagues at Gnosall and rolled out across Stafford and Cannock CCGs. Cconsultation with people living with dementia and carers in Leeds indicates a strong preference for an alternative title, to be clearer about the role.

- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The Eldercare Facilitator role will be mainly post-diagnosis: to befriend and build trust; support people to come to terms with living with dementia and what this means for each person; to inform and connect people and carers reliably and consistently to post- diagnosis support. Local evaluation[2] has shown we often fail to link people to the range of support and services available in Leeds.

This means, per full-time equivalent, being a named point of contact for 400-450 people living with a diagnosis of dementia. Intervention is focused initially on the immediate post-diagnosis period, an average of 100-120 people per FTE per year. This will take place mainly at home visits.

Old age psychiatry and memory service clinic sessions to take place in GP surgeries (initially one location in each of the 13 neighbourhoods) working as virtual teams with GP practices and eldercare faciltator. The estimated capacity required for the whole of Leeds is 83 half-day sessions per month, shared between the team of old-age psychiatrists and specialist doctors.

Revise memory service specification to: facilitate this closer link to primary care; include a standard of post-diagnosis education and non-drug treatment (eg. cognitive stimulation therapy); and simple access back to the service when needed.

Review local guidance for Donepezil and other Alzheimers medication. To remove unnecessary tasks from the monitoring process (given that ongoing prescribing is less of an issue now that costs have reduced significantly); make clear the requirement to use Donezepil as most cost-effective AChEI[2] option, unless contraindicated; describe when specialist services should become involved again.

The Eldercare Facilitator will support self-management plans and case management interventions, a resource to support the capacity of primary care, help implement interventions eg. arising from the unplanned admissions DES, and the Integrated Neighbourhood teams. They will therefore have an impact to reduce acute admissions and readmissions. There will be more capacity for practices to stay in touch with people and monitor situations, rather than people 'falling off the radar' until an emergency happens.

The redesign will bring the expertise of specialist services and primary care together to achieve integrated care for people with dementia and co-morbid conditions linked to ageing, and strengthen formal and informal links between clinicians. It will avoid the duplication / fragmentation arising from Alzheimers medication reviews at a memory clinic; whilst primary care carries out annual dementia reviews (QOF DEM2). It will end the inappropriate, prescribing- led, variation in post-diagnosis information and support.

The specialist nurses and OTs in the Leeds memory service will be released from routine reviewing to reduce waiting times for memorya ssessment; to deliver post-diagnosis education and treatment; and respond to re-referrals when there are significant changes in eg. a person's dementia, social circumstances, behaviour.

Leeds City Council (adult social care) will tender for the Eldercare Facilitator service, and there is known interest from local third sector providers as well as scope for NHS providers to bid.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

[2] Dementia In Leeds Evaluation project 2013, available to download from www.leeds.gov.uk/dementia

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The delivery of the redesign is overseen and co-ordinated by a Working Group, chaired by Nicola Dumphy, clinical lead for mental health, dementia and LD for Leeds S+E CCG; and supported by Tim Sanders, Commissioning Manager for Dementia, a joint health and social care post employed by Leeds City Council. The group includes old-age psychiatry lead (Wendy Neil), medicines management (from commissioner and specialist provider), Practice Nursing lead from Leeds North CCG, commissioning managers responsible for locality working from all three Leeds CCGs, the local Alzheimers Society, Leeds Involving People, and support from the regional Strategic Clinical Network.

Leeds North CCG is the lead commissioner for the contract with Leeds and York Partnerships Foundation NHS Trust (LYPFT) and the development of the service which forms part of this redesign is part of the agreed service specification.

Leeds City Council (LCC) is starting the procurement process for the Eldercare Facilitator roles – at the time of writing, a timetable is awaited from LCC procurement unit. However, it is anticipated that contract award will be in January 2014. Tim Sanders is leading on the procurement.

Heather Edmonds (Leeds North CCG) and Anita Solanki (LYPFT) are the medicines management leads reviewing the local 'amber drug' guidance for the three anti-cholinesterase inhibitors prescribed in dementia, and memantine.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The Leeds Dementia Strategy (*Living Well With Dementia In Leeds*, 2013) set the local direction for closer working between specialist services and primary care; connecting the ambition to increase diagnosis strongly to that for post-diagnosis support (so diagnosis is not reduced to chasing numbers); a review of patient and carer experience, and review of 'shared care' for dementia medication. The evidence base included:

- Leeds GP register data showing that 90% of people with a dementia diagnosis had at least one other long-term condition;
- Leeds Memory Service activity (contacts per year) had increased significantly whilst waiting times had increased to April 2013, fitting the clinicians' view that a disproportionate part of their activity was routine reviewing.
- Innovations elsewhere in the country improving diagnosis and post-diagnosis support by implementing primary care based models.

The evaluation of experience on the dementia pathway was published in September 2013[3]. This identified that carers especially valued the diagnosis in its own right, as making sense of changes and behaviours; but that people often felt left 'high and dry' after a diagnosis. The project tested out people's views on increasing the role of GP practices, and indicated that, whilst some people would welcome the opportunity to be supported closer to home, there was concern about loss of specialist support. It was pointed out that the ambition for early diagnosis favours the continuing role of specialists.

Commissioners appraised options for primary care models, based on three from elsewhere in England:

a. Bristol – GPs have taken on more diagnosis and initation of prescribing, supported by a primary care liaison service. Not favoured because not backed widely by local GPs,and old-age psychiatry acknoeledged as able to diagnose more accurately at earlier stages. However, it was agreed that Leeds should increase GP role in diagnosis at later stages, as described in Joint Commissioning Panel guidance[4]; people can remain undiagnosed if GPs decide not to refer frail older people with more advanced dementia to memory services.
b. Hastings, Sussex – primary care memory clinics run by GPs with Special Interest in Dementia. It was felt that we already have the right clinical expertise available, and if anything GPs with SI are more expensive. The training provided by Bradford Dementia Group was offered to local GPS, including funding for practices to backfill, but there was no interest expressed.
c. Gnosall – old-age psychiatrist provides a monthly memory clinic on the premises of the local GP practice. Eldercare Facilitator supports memory assessment and post-diagnosis. This was agreed as the basis of our preferred model, based on making best use of clinical expertise and addressing the issue of post-diagnosis support. However, the existence of qualified specialist nursing and OT within the memory service is a strength that Leeds enjoys, and we do not wish to lose this from the early stages of the dementia journey, or the opportunity for closer working with community services.

The final proposals were tested out in consultation with people living with dementia and carers; GPs; and all partners via the Leeds Integrated Dementia Board.

The Gnosall model has been in operation for seven years and has now been rolled out across two CCG areas – Stafford and Surrounds, and Cannock and Surrounds, with 280,000 population. Published evidence points to very high patient and carer satisfaction; and 100% of expected prevalence either diagnosed with early memory problems, or actual dementia. Michael Clark at London School of Economics has reviewed acute admissions data and identified that Gnosall surgery's spend on acute admissions is £450K below expected average for population profile for 8,000 population, with Eldercare Facilitators linked to a range of primary care initiatives re. dementia and frailty[5].

In Leeds, there has been initial analysis of hospital admission data, divided into subsets identified by the national dementia CQUIN for acute care. This enables us for the first time to compare inpatient episodes (primary diagnosis, length of stay, admission tariff, cost) according to whether dementia was already diagnosed on admission; or memory problems identified by the CQUIN; or no dementia indicated.

There are c. 3,800 people aged 75+ in Leeds with a diagnosis of dementia in Leeds, with an estimated

[3] *Dementia in Leeds Evaluation Project,* available at www.leeds.gov.uk/dementia
[4] RCGPs / RCPsych, www.jcpmh.info/good-services/dementia-services/
[5] http://blogs.lse.ac.uk/healthandsocialcare/2013/05/07/putting-personalisation-and-integration-into-practice-in-primary-care/

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[3].

The analysis of local data suggests that:

- 2,400 admissions were identified for people with dementia diagnosed or suspected, out of 8,900 total for people aged 75+; this is an underestimate given that it does not include admissions where the CQUIN process was missed.
- people with dementia are estimated as 13% of the general population aged 75+; but are almost 40% of those admitted with falls and / or fractures; and almost 45% of the bed-days and costs of those admissions.
- Average cost per admission of a person with dementia / memory problems is c. £4,000.
- Average length of stay was 2 days greater for people with dementia or memory problems; however, this did not usually exceed tariff 'trim-point' because people were allocated to more complex tariffs.

This tells us that:

- there is a need to fully include people with dementia in admissions avoidance initiatives and that the primary causes are among those commonly identified as preventable.
- the Eldercare Facilitator role can provide capacity to support reduction of admissions, including readmissions, forming the basis of an "invest to save" case;
- people living with dementia have a strong likelihood of being in the "top 2%" of people at risk of rising care costs, and on the 'caseload' of Leeds Integrated Neighbourhood Teams. Although they are envisaged as part of the primary care team, the allocation to each of the 13 neighbourhoods will enable strong links to develop, to support transitions from' self-management' to 'case-management', and back again.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£435K to employ 13 Eldercare Facilitators (c. Band 4 / unqualified social work equivalent) plus a manager role, including on-costs.
£130K to pay GP practices for accommodation and support for memory clinics, admin and other work. (£10K pa per neighbourhood).
BCF TOTAL - £565K pa.

Additional resource available: dementia and workforce funding carried over from 2013-14 to support Eldercare Facilitator and primary care training. c. £25K one-off funding.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

On patient experience:

- shorter journeys and reduced stigma from service delivery in nearby primary care setting.
- direct booking into memory clinic via primary care system without delays caused by referral admin.
- access to post-diagnosis support from dedicated staff role, which has not been available for people with a vascular dementia and others not prescribed dementia drugs.

On Activity :

- 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 – 200 fewer acute admissions.
- 2016-17: 2,500 people with dementia with preventive person-centred plans in place – 400 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.

On Cost :

- Average cost per admission is £4,000 identified from above work on Leeds Teaching Hospitals admissions and dementia CQUIN data. To be conservative, this calculation uses a figure of £2,000 per admission to allow for other services and investments contributing to admission avoidance.
- 400 acute admissions therefore corresponds to £800K savings.

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.

+ Local measures: increase dementia diagnosis rate (though this will be after the timescale for the March 2015 ambition to get to 67% of estimated prevalence).

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

The proposal aims to achieve improvements in experience of people living with dementia, including families and carers; integrated working and mutual support between primary and secondary care; and reductions in avoidable admissions to hospital. This will require a range of

measures that cover both service outcomes and population outcomes. The Leeds programme for adult integrated care uses the Outcomes-Based Accountability approach. The Strategic Clinical Network dementia lead has agreed to discuss evaluation of the redesign with the Academic Health Science Network (AHSN).

Metrics will include:

- patient and family carer experience, eg. satisfaction with timeliness, and quality.
- clinician experience of new working arrangements.
- Eldercare Facilitator reports of involvement in preventive care plans
- individual narratives, including counterfactuals of likely outcome prior to intervention.
- subset of acute admissions for preventable causes for people with dementia diagnosis and memory problems; admission costs , lengths of stay.

These will require new surveys and data collections; and work to develop a dementia "subset" of hospital admission data.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- The commitment of all partners, based on strong networks governed by Leeds Integrated Dementia Board, and the level of engagement and negotiation involved in the design of the proposal.
- The continuing high priority attached to dementia care, nationally and locally, underpinning the commitment of colleagues from eg. medicines management, CCG locality teams.
- The programme design under the Leeds Transformation Board, enabling links to be made between long-term conditions, primary care development and admission avoidance.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- lack of accommodation for clinics in primary care, therefore prioritising one clinic location in each of the 13 neighbourhoods;
- IT system requirements and timescales for any improvements. Early discussion with timescales in parallel with procurement process for eldercare facilitators.
- GP practices might not trust Eldercare Facilitators with sensitive data and therefore withhold 'honorary contracts'. Include quality assurance and compliance standards in provurement process, and involve GP representation on evaluation panel if possible.
- Some old-age psychiatrists might resist moves to primary care clinic locations. Reassure re. relatively small number of monthly sessions; consider keeping community arrangements where they exist already, with alternative ways of engaging with primary care.
- pressures on primary care will affect GPs' trust and acceptance of new working arrangements eg. represcribing dementia drugs without memory clinic recommendation. Ensure new arrangements take GP and practice nurse workloads and training needs into account, and offer clear pathway to specialist advice and services when required.

- delays in taking routine reviewing from memory service will limit capacity to see new referrals promptly.
- impact of early and preventive support is difficult to track and quantify. Track chain of causation via involvement in preventive care plans.
- people with dementia and families may choose to attend A+E even when care plans and management are in place, especially if person presenting with delirium.
- increased cost of eg. domiciliary services and intermediate care services meeting needs outside hospital

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Start date: August 2014.
Redesign implemented: spring 2015
Evaluation: summer and autumn 2015.

Eldercare Facilitators:

- procurement timetable set – September 2014
- out to advert – c. October 2014
- selection of provider – January 2015
- staff in post – March 2015
- training programme – March / April 2015.

Memory clinics in primary care:

- identification of venues: Sept – Dec 2014
- agreements in place with GP practices: Jan / Feb 2015
- evaluation of GP systems v requirements – Nov 2014.

"Year of Care"

- review of dementia drug guidance – Dec 2014
- design of annual review process – Feb 2015
- implementation – summer 2015

SCHEME NAME :- Medication management and memory problems	
SCHEME NO	**13**
RESPONSIBLE GROUP	**Tim Sanders with** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	**Tim Sanders**
VERSION & DATE	**V2, 12/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

To meet the needs of a cohort of people who cannot manage medication, and do not have informal care or care services available for support; or where there is support, carers or staff need advice or training to get medication right. To take an innovative, integrated approach involving medicines management, assistive technologies, community services and third sector. Difficulties with medication may be linked to behavioural and psychological needs in dementia and exacerbate informal carer stress.

Specific strategic links:

- Leeds Dementia Strategy – priority for diagnosis to lead to post-diagnosis and self-management support.
- Integration and the BCF as an opportunity to resolve a long-standing local difficulty.
- Self-management support for diabetes, vascular disease, hypertension – people with these conditions are at higher risk of memory problems, and problems with medication may severely exacerbate these conditions.
- Reduction of hospital admissions linked to problems with medication compliance (risks apply to both forgetting to take it; forgetting one has taken it).
- West Yorkshire Community Pharmacy sign-up to Dementia Action Alliance and commitment to dementia-friendly pharmacies.
- Leeds priority to tackle loneliness; people who have no-one to help with medication may well be isolated socially. We can link this new pathway to a range of third sector services, and developments with £6m Big Lottery funding.

Adult social care policy has for some time been to offer a medication prompt as part of a larger care package where care staff are visiting for other support tasks, but not as a standalone service. However, there is local evidence that even when this is provided, Community health services are commissioned to provide some capacity for support, but this is always below the demand for prompts.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?* I
- *Which service user/ patient group is being targeted? What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The model for the scheme is still in design, and a small, amount of BCF funding will be used in 2014-15 to work up the scheme, including one day per week for six months of Leeds Community Healthcare pharmacy technician as project support.

The group of people benefitting from the service is, broadly, anyone with memory problems which affect the ability to take the right medication – the preferred approach is *not* to apply restrictive criteria (eg. only confirmed diagnosis / dementia medication). An initial estimate is that 2,000 people per year may benefit from a person-centred approach to optimise medication and identify solutions including Telecare; 200 people at any one time needing at least one daily prompt visit at home. Further data is being sought to improve these estimates.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

It is likely that the model will involve:

- Leeds S+E CCG commissioning Leeds Community Healthcare to increase capacity of Pharmacy Technician Team.
- Leeds City Council commissioning domiciliary care from existing contracted providers, perhaps with a selection process to choose a smaller number of providers for this service.
- Leeds North CCG commissioning LYPFT to ensure specialist advice and guidance is available from the Leeds Memory Service, to develop person-centred solutions.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

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.

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.

Leeds GP data shows that 90% of people with a diagnosis of dementia have at least one other “Year

of Care" long-term condition. 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.

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.* [1]

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.*[2] This scales to c. £0.5m - £2m pa. for Leeds, though proportion attributable to older people and memory problems is unknown.

There is published evidence from a Leeds pilot project, in which Leeds Teaching Hospitals Trust pharmacists offered medicines review to people who *already have a medication prompt service* as part of a domiciliary care package[3]. "Recurring themes" included problems with compliance aids (Telecare), communication about changes on hospital discharge, inhaler technique for asthma, and medicines not being used (finding excess and expired medication). This suggests that elements of the new service should extend to people already receiving prompts.

Anecdotal evidence, including carer representaive on Leeds Dementia Board, of the stress involved in ensuring medication is taken.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£10K to work up during 2014-15.

Initial very rough estimate of costing:

- 2,000 people per year for person-centred planning and optimisation of meds @ £50	= £100K
- 200 people requiring daily (*365) prompt visit @ £3	= £220K
TOTAL	**£320K**

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about*

[1] http://www.scie.org.uk/publications/briefings/files/briefing15.pdf
[2] http://www.nice.org.uk/nicemedia/pdf/CG76CostStatement.pdf
[3] *Domiciliary Pharmacy Technician Medicine Reviews For Patients Having Home Care Medicines Assistance*; Pharmacy Management Volume 30 Issue 1, http://pharman.co.uk/volume-30-january-2014

future outcomes?

Impact on BCF National Conditions/BCF Performance Targets

- Protection of Social Care – relieving pressure on services arising from disputed responsibilities.
- Accountable Lead Professional – would strengthen self-management arrangements and avoid some escalations to case management.
- Emergency Admissions– reduced admissions

'Intelligence suggests 90% of dementia patients have one or more co-morbidities that require regular medication. Where an individual doesn't have regular care in place there is a risk of unplanned hospitalisation due to lack of compliance with medications. We estimate this will reduce admissions by the required level to at least meet the investment.

Intelligence suggests 90% of dementia patients have one or more co-morbidities that require regular medication. Where an individual doesn't have regular care in place there is a risk of unplanned hospitalisation due to lack of compliance with medications. We estimate this will reduce admissions by the required level to at least meet the investment.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Metrics:

- Number of plans made, including counterfactual information about what risks have been managed and potential adverse outcomes.
- Number of people who cannot be prescribed Anti-Cholinesterase Inhibitors for Alzheimers Disease, because of the lack of availability of a medication prompt.
- Practice nurse / GP reports of number of patients attending for long-term condion reviwes where there are medication management concerns linked to memory / cognitive concerns.
- If we can identify a subset of acute hospital admissions which are likely to be attributable to medication non-compliance ?

These will all require work to design and capture the metrics.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and

ii) engagement with partners about the deliverability of the proposal
- Commitment to developing an integrated model rather than "more of the same". Engagement of partners through workshop on October 2nd. - Stepped approach of developing options; appraisal and design; pilot; evaluate; roll out
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
To be developed. Basically risks associated with an innovative approach.
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
Aiming for new service to start April 2015. Design period will be a few months, but commissioning is likely to be relatively modest financial changes to existing contracts rather than requiring procurement.

SCHEME NAME :- Falls Pathway scoping	
SCHEME NO	**14**
RESPONSIBLE GROUP	**Lucy Jackson** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Funding for post – proposed Agenda for Change 7 or equivalent (if 9 months – 33K)
Funding for two stakeholder events (2K)
Admin support

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population (sub divided for 65 to 79 ; over 80s)

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

2014/15 - £50k
2015/16 - £500k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*

- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Older people (via Leeds Older Peoples Forum) ;CCGs; LCH; LTHT; YAS; Primary Care; IHSCTs (ASC/LCH)
Impact on Activity
Modelled deaths in Leeds due to falls 58; estimated hospital admission due to falls in Leeds 2495

Impact on Cost :
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**

FEEDBACK LOOP
What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME - *E.g. expertise, staff, demographics, history of partnership working.* - *Do these also exist within the local area?* - *If not – have actions been put in place to resolve this?* - *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?* - *An outline of a stepped approach to implementation which draws on* *I) learning from either local evaluation or other areas where this has been implemented, and* *ii) engagement with partners about the deliverability of the proposal*
It is expected that this scheme will have its largest impact on reducing non-elective admissions. It is likely that it will also impact on admissions to residential care. The exact size of the impact will be modelled during the course of 2014/15.
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
Will be managed by the integrated system change group.
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
April 2015

SCHEME NAME :- *Reducing Admissions and reducing delayed hospital discharges*	
SCHEME NO	**15a & 15b**
RESPONSIBLE GROUP	Integrated Health & Social Care Board
ACCOUNTABLE LEAD OFFICER	Diane Boyne**/**Paul Morrin/ Sam Prince/ Dennis Holmes
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.
Total cost £650,000.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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 DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

- No. acute admissions avoided(from home and from A&E/assessment floor) due to timely availability of CIC bed
- No. bed days delayed hospital discharge due to lack of CIC availability
- No. patients referred for CIC bed whilst in A&E but are actually admitted to a CIC bed from a hospital ward
- Increase in community services activity (health and social care)
- Use CareTrak to monitor longitudinal outcomes

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

the commissioning of 12 beds (FYE)	£410,000
additional LCH staffing to support the beds	£180,000
enhanced GP cover	£10,000
Bed Bureau 7 days	£50,000
Total:-	**£650,000**

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Nursing care home providers- need to provide additional capacity with a guarantee of 12-bed level of provision
- Neighbourhood teams – notably Community nursing, therapy and social work staff, primary care, Health Trainers, specialist services, voluntary sector organisations.
- Acute services – particularly in relation to interface functions e.g. discharge planning
- LCH EDAT/Interface geriatricians/A&E and assessment floor staff – awareness needed of the change to the pathway and the 'protected' CIC capacity
- LSECCG – commissioning and contracting lead on LCH contract and nursing home contracting
- Integrated Health and Social Care Board/Transformation Board – to monitor and review impact of these proposals alongside other service developments

All of the key providers will be required to work in an integrated and collaborative way centred around the patient and their personalised care plan

Impact on Activity

Reduction in acute admissions

Reduction in acute hospital admissions from A&E and the assessment floor by 420 per year

Assuming under the new pathway patients diverted from A&E direct to the CICU sub-acute ward have an average length of stay on this ward of 4 days, 7 of the 12 additional beds will also be available to support patients discharges from hospital wards (which is recognised as a pressure point for DToC). These extra 7 beds should help reduce DToC by 2,500.

Impact on Cost

Reducing acute admissions

Based on a range cost of the hospital stay for this cohort of patients of £1,500-£2,000 per stay, the current cost of these avoidable acute admissions is £630,000-£900,000 p.a.

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. **+ve**
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 **+ve**
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. **+ve**
4. **Better data sharing between health and social care based on the NHS number T**he 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 ahs 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 multiprofessional 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. **+ve**

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. **+ve**
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. **+ve**
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. **+ve**
4. **Avoidable emergency admissions** – community beds will enable people to be maintained in a community setting, avoiding hospital admission **+ve**
5. **Patient / service user experience** – patients and families will be supported to remain in a community setting closer to home **+ve**

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

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*

- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

This is currently being worked up locally and will be confirmed between now and December 2014.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Supply leads demand- more CIC bed availability results in fewer patients going directly home (mitigation- tighten triaging & referral process for the beds).

Workforce- sufficient nursing/therapies/other staff are available to support the additional beds (mitigation:- LCH already made aware of the potential additional staffing required and the potential need to carry forward their additional winter pressures staffing into 14/15)

- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal. Benefits stated are based on estimate/prediction rather than actuals.
  Ability to specifically attribute savings to these proposals as opposed to savings in systems

  To Other Parts

Savings deriving from a reduction in unplanned acute admissions can only be cashed if overall hospital activity reduces

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Some impact during Q4 of 2014/15, with full implementation and impact from April 2015.

SCHEME NAME :- Increased Community Nursing Capacity to support care at End of Life and enhance 7 day working

SCHEME NO	**15 c**
RESPONSIBLE GROUP	**Effective Discharge and admissions group**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan/Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This proposal is to increase the capacity in the community nursing service at a neighbourhood level (with a specific focus on district nursing services) supporting improved care for End Of Life (EOL) patients and 7 day working.

The service model for this proposal is to deliver the additional capacity to support the above areas within the developing Integrated Neighbourhood Teams (INT). Thirteen INTs are under development providing nursing, therapy and social work input at neighbourhood level, wrapped around GP practices. The additional posts will join the INTs and be managed within the INT leadership and management structure, ensuring that the additional capacity has maximum impact on patient care.

For indicative purposes the proposed funding will support additional posts as follows:

- 2.4 wte x administrators
- 23.5 wte community nurses

The exact staffing structure will be finalised as part of ongoing work to develop integrated neighbourhood teams. Commissioners will be updated with the final staffing structure once agreed.

We intend that this capacity will be in place by the beginning of Quarter 3 2014/15.

All of the key stakeholders will be required to work in an integrated and collaborative way centred on the patient and their personalised care plan, in particular improving coordination of care for patients approaching end of life. The effective and consistent use of EPaCCS and implementation of the Leeds Care Record is critical to this.

Neighbourhood teams are in the process of being established - this is part of the neighbourhood team offer and will be delivered as part of the Integrated Neighbourhood team.

Acute hospital services – particularly in relation to the interface functions e.g. discharge planning

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This proposal will expand capacity in integrated neighbourhood teams in order to work with primary care to:

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

transfers of care
- improve performance in meeting people's health needs as they approach the end of life

The increase in community nursing capacity will improve 7 day working and flow.

The End of Life Health Needs Assessment (HNA) recognised the need to increase District Nursing capacity to deliver all aspects of end of life care currently and as the numbers of people approaching end of life and choosing to be cared for and die in their usual place of residence increases.

To date there has been a reduction in the number of people dying in hospital nationally and in Leeds. Leeds ONS data referred to in the HNA shows a decrease in hospital deaths from 50.2% in 2007 to 48% in 2011. Deaths at home have increased from 19% to 21% over the same period and increasing capacity within neighbourhood teams should enable this figure to continue rising.

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

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

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£500k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Patient satisfaction measures to be developed in line with the city wide work plan for End of Life care
- Improved adherence to Service Delivery Framework for End of Life Care, including bereavement support
- Increase the numbers of Independent Nurse Prescribers within neighbourhood teams actively prescribing for patients approaching end of life.
- Increase the number of nurses who can verify expected death within neighbourhood teams.
- Maintain current PPD target for an increasing number of End of Life Care patients cared for in usual place of residence
- On going review of citywide EoLC data collated by the CCGs from 2014/15 Q1 in line with HNA recommendations

During Q2 2014/15 LCH will develop key metrics and baselines for the above indicators as the service model develops, in conjunction with commissioners. The Adult Business Unit Business manager with identified performance management resource will support this work.

- Estimated total additional activity for the additional resource would be c30,000 contacts (FYE), depending on the final service delivery model agreed.
- The proposals will improve other aspects of quality:
    - providing more early support to patients recognised as palliative;
    - potentially improving symptom control by increasing the numbers of Independent Nurse Prescribers actively prescribing for patients approaching end of life;
    - reducing the need for GP visits in and out of hours through this increased prescribing and more nurses being trained to verify expected death.

For illustrative purposes
The range of possible contacts is:

Minimum - 22,500 (based on x 1 daily contact for 1 month at intermediate stage and x 2 daily contacts for 1 week at intensive stage).
Maximum - 112,000 (based on x 1 daily contact for 3 months at intermediate stage and x 3 daily contacts for 2 weeks at intensive stage).
and obviously a whole range in between! There are a whole load of variables within that range.
This is based on an assumption of 500 patients a year.

Based on the investment proposed and using current average number of contacts per WTE based on the current contract for DN -24 services.
The proposed investment buys 23.5 WTE clinical staff (based on B5). we know that in reality we are likely to further skill mix this to provide best overall skill mix in developing Integrated Neighbourhood Teams. Working on assumption of 23.5 WTE the revised proposed total increase in F2F contacts would be in the region of 35-40,000.
For illustrative purposes this could be broken down as follows:

1 month x1 contact daily (15,500 contacts) +2 weeks x 2 daily contact (14,000 contacts) + 4 days x 3 daily contacts (6,000 contacts) = 35,500 contacts
If additional contacts were required (nearer the 50,000 level), additional investment would be required accordingly to increase the WTE capacity available.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can*

be achieved? - *An outline of a stepped approach to implementation which draws on* *I) learning from either local evaluation or other areas where this has been implemented, and* *ii) engagement with partners about the deliverability of the proposal*
• Strong partnership working between LCH and LTHT • Skilled staff with comprehensive knowledge of community services available
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
• A lot of change is being undertaken at the same time within community nursing and the neighbourhood teams - interdependencies with this work. • Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts. This is being mitigated by increased recruitment resources and staff being recruited on a permanent contracts (risk to be shared with commissioners). • The benefits stated are based on estimate/prediction rather than actual. • An increase in the numbers of patients approaching end of life being supported by integrated neighbourhood teams is dependent on earlier identification and referral of patients by other services • Ability to specifically attribute savings to these proposals as opposed to savings in system per se
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
The scheme will be implemented by April 2015

SCHEME NAME :- Homeless Accommodation Leeds Pathway (HALP)	
SCHEME NO	**15 d**
RESPONSIBLE GROUP	**Diane Boyne**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan / Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

There will be a dedicated referral system in to the Homeless Accommodation Leeds Pathway available 24 hours 7 days a week

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

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

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

3rd sector provider and understanding pathway for these patients from acute Trust.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

- Annual cost of inpatient hospital care for homeless patients is 8x that of housed population aged 16-64.[1]
- Homeless people attend A+E 5x as often as housed population, are admitted 3.2x as often and stay 3x as long[2].
- 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 yrs and associated with the reduced quality of life caused by multi-morbidity[3]

[1] Office of the Chief Analyst. Healthcare for single homeless people. Department of Health, 2010. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250

[2] *Ibid*

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[4]

Timely response	**Assessed within 2 working days (unless self discharged)**	**80%**	**Audit of referral and assessment records**	**monthly**
Reduction in prolonged hospital stay once well	**Reduction in total bed days for homeless people**	**30%**	**Audit of hospital admission data**	**monthly**
Homeless people staying well for longer once discharged	**Reduction in readmissions**	**20%**	**Audit of hospital admission data**	**monthly**
Improved access to specialist primary care	**Registration at York St**	**70%**	**Records audit**	**monthly**
Patients have an integrated care plan	**Patient has a Care plan**	**100%**	**MDT meeting minutes**	**monthly**

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

	St Georges Crypt	Partner	Total
Employee Costs			
24/7 support for 3 rooms over project duration	£70,488		£70,488

[3] Crisis 2011. Homelessness: a silent killer. London Dec 2011. http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf

[4] 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

GP Costs		£49,735	£49,735
Nurse		£36,693	£36,693
Support Worker x 2		£50,353	£50,353
Staff Training	£1,200		£1,200
Sickness and holiday cover for staff absence	£4,800		£4,800
Total Costs for the duration (10 Months)	**£76,488**	**£136,781**	**£213,269**
Costs (Travel, Emergency consumables)			
Travel costs (residents to appointments) Travel costs staff	**£480**	 **£500**	**£480** **£500**
Drugs, Dressings		**£1,500**	**£1,500**
Running Costs			
IT Support	**£600**		**£600**
Stationary	**£240**		**£240**
Utilities	**£360**	**£800**	**£1,160**
Consumables e.g. washing powder, laundry	**£240**		**£240**
Clinical Waste disposal	**£960**		**£960**
Corporate overheads		**£20,937**	**£20,937**
Total revenue cost	**£79,368**	**£160,518**	**£239,886**

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Hospital staff identify homelessness and make timely referral to HALP
- York St Practice to accommodate increased number in new registrations and rapid response to ensure smooth transition from hospital
- Increase in referrals to Housing Options as homeless people are identified and signposted

On Activity,

- 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
- By case managing homeless patients on discharge from hospital there is an expectation that re-admissions to hospital for this cohort will be reduced. Assuming a 20% reduction in re-admissions, this equates to 41 avoided admissions per year.
- In Leeds around 50 bed days are lost in hospital each month due to DToC associated with housing issues. Whilst not all of these cases will involve homeless people, there is an expectation that by providing step-down beds through the HALP scheme, DToC for the homeless cohort will be significantly reduced, with an estimated saving of 17 bed days per month (a third of all housing-related DToC).

On Cost,

Measurable outcomes:

- A reduction in readmissions of homeless people to hospital- unable to estimate due to complexity of hospital tariff
- A reduction in total bed days for homeless people in hospital - £217K

1652 bed days 30% reduction in hospital length of stay.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in

the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

These are currently being developed.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

To Success ,

- Reliant on hospital staff identifying appropriate referrals
- Relies on the availability of both emergency and permanent accommodation
- Small number of HALP beds

To Other parts of System,
Increased workload for other agencies as need is identified and signposted

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*

- *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
Implementation during 2014/15, continued into 2015/16.

SCHEME NAME :-	Leeds Equipment Service 7 days a week opening

SCHEME NO	**16a**
RESPONSIBLE GROUP	**Effective discharge and admissions**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan/Sandie Keene**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Leeds Community Equipment Services (LCES) provides equipment on a loan basis to patients living in Leeds, to allow them to live safely within their own home. The equipment provided ranges from specialist beds, mattresses and hoists to relatively inexpensive walking aids. Without this equipment many people would need to be admitted to hospital as front line services would not be able to provide adequate/ safe care/ treatment.

The provision of loan equipment is also a key component of many discharge packages, allowing patients to return home to be cared for by community services/ family.

LCES is a critical part of the care system, and without equipment many services (acute and community) would not be able to operate, as community services would have to admit patients to hospitals that were full due to them not being able to discharge patients.

In December 2013 the South and East CCG agreed to fund a pilot to enable LCES to open 7 days a week, as part of the "winter pressures" initiatives. This business case is requesting £130k of funding to continue to deliver a seven day a week service, in effect making seven day a week working the norm, in line with other local and national initiatives. The formal review paper detailing the pilot will be produced in March 2014, however this paper uses the early results of the pilot as the basis of business case.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The pilot has allowed LCES to open from 8.00am to 4.00pm on a Saturday and Sunday, with an emphasis on providing urgent equipment to facilitate early patient discharge or to reduce the need for patients to be admitted to hospital. The pilot started slightly later than planned (22/12/13) and the Saturday/ Sunday service has been provided as scheduled every weekend since.

The pilot is due to end at the end of March 14, unless commissioners agree to fund the seven day a week service on a permanent basis beyond that date.

The business case is requesting an additional £130K of funding, mainly for staffing resources (see Appendix 1).

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.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The LCES were funded to provide a 7 day service through winter. Following positive feedback from the Acute Trusts and the Community Services, as well as patients, there is a need to maintain this level of service which support system flow.

The expectation is that there will be no break in the 7 day service and that it will continue throughout 2014/15 during which time we will continue to evaluate the impact on admission avoidance and hospital discharge.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The original pilot was established to enable LCES to continue operation across the winter months, increasing capacity to meet the flex of the LTHT services during the winter period. It was hoped that this would enable LCES to contribute to the prevention/reduction of delayed transfers of care from hospital by being able to deliver necessary equipment following the relevant clinical assessment to people returning home, and contributing to the reablement programme aimed at reducing reliance on large packages of care. It will also hoped that the pilot would contribute to the reduction of people requiring permanent care following hospital admission by the provision of appropriate equipment

The benefits for this were thought to be:

- To meet the increased demand on the service through the winter months.
- To ensure that patients receive equipment to enable them to be treated in their own homes and avoid the need for admission to hospital.
- To continue to support hospital discharge by providing requested equipment
- Test the demand, costs and practicalities for a 7 day a week LCES service

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£130k in both 2014/15 and 2015/16

Additional weekly pay costs

No	Staff Group	Sat	Sun	Cost – including on costs and enhancements
2	Cleaners – Band 2	7.5	7.5	
1	Admin – Band 2	7.5	7.5	
1	Storekeeper – Band 3	7.5	7.5	
1	Driver – Band 2	7.5	7.5	
1	Fitter – Band 5	7.5	7.5	
1	Fitter – Band 4	7.5	7.5	
1	Manager – Band 5-7	7.5	7.5	
			Total	£130K

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about*

future outcomes?

Activity

Although the seven day a week service has only been running for a month, it is clear that the system has been welcomed by hospital and community services. The details of the deliveries, fittings and collections are detailed in Appendix 2.

The initial figures show that between 25 and 36 patients are being helped each day. These are all urgent cases, and most of them could have had to go into hospital. There were also a small number of weekend discharges that LCES helped by providing essential equipment.

There has also been an additional 29 pieces of equipment collected directly from stores – up to 8 collections per day.

Yearly comparison of activity

2012/13				
Month	**Total Issues**		**Total collections**	
Dec-12	**6176**		**3636**	
Jan-13	**6471**		**5224**	
Feb-13	**6936**		**5519**	
Mar-13	**6588**		**4380**	
2013/14				
Month	**Total Issues**	**Difference**	**Total collections**	**Difference**
Dec-13	**7357**	**1181 increase**	**4698**	**1062 increase**
Jan-14	**7050**	**579 increase**	**6042**	**818 increase**
Feb-14				
Mar-14				

Yearly Comparison of Key Performance Indicators

2012/13			2013/14		
Month	% Delivered within 7 working days		**Month**	% Delivered within 7 working days	
Nov-12	97.74%		**Nov-13**	96.89	-0.85

Dec-12	98.29%		**Dec-13**	99.13	+0.84
Jan-13	97.77%		**Jan-14**	99.35	+1.58
Feb-13	92.78%		**Feb-14**	99.63	+6.85
Mar-13	95.03%		**Mar-14**		

Benefits

The original benefits of the pilot related to:
Winter pressures demand – LCES has managed all of the demand from the "winter pressures" period, and has not had to turn down any request for urgent delivery/ collection.

Admission avoidance – Ability to deliver equipment to people at home will improve the quality of care and also reduce the need for unnecessary admission. This is particularly the case for people at end of life and frail older people.

Early discharge – fewer people will be delayed in hospital as the equipment required to deliver care will be delivered Saturday and Sunday (7 days service). This will reduce the risk of hospital acquired infections etc. as well as releasing beds

Lessons learnt – LCES has learnt a lot during the pilot, and the following changes will be implemented if this proposal is accepted:

- New shifts - All relevant staff will be on a rota to work weekends. This will provide a more robust way of covering the weekend shifts.
- Management support – It is important that staff working on weekends are supported if anything unexpected happens. This proposal includes a manager working each weekend.

In addition to the above, the following benefits have been seen during the pilot:

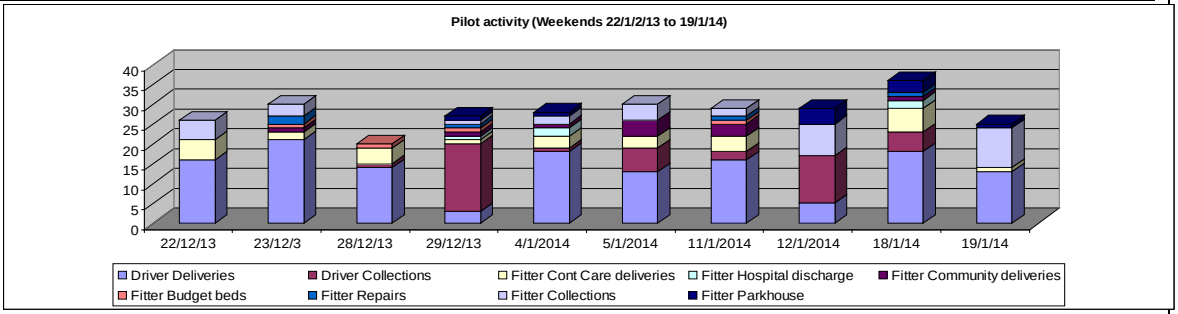
- Emergency repairs of critical equipment can now be picked up by LCES instead of expensive external contractors
- Peripheral equipment stores that were set up for clinical staff to access equipment on a weekend can be reduced. This saves clinical staff having to deliver equipment.
- The service is able to collect more equipment, especially on a weekend when carers or more likely to be available.
- The peaks and troughs of the scheduled work have been smoothed out, in particular the normal Monday morning rush to catch up with urgent deliveries has been eliminated.

A more detailed review of the pilot will be produced in March 2014, giving a more detailed picture of the benefits.

Appendix 2 – LCES weekend activity

		22/12/13	**23/12/3**	**28/12/13**	**29/12/13**	**4/1/2014**	**5/1/2014**	**11/1/2014**	**12/1/2014**	**18/1/14**	**19/1/14**
Drive	**Deliveries**	16	21	14	3	18	13	16	5	18	13

r	**Collections**			1	17	1	6	2	12	5	
Fitter	**Cont Care deliveries**	5	2	4	1	3	3	4		6	1
	Hospital discharge				1	2				2	
	Community deliveries		1		1	1	4	3		1	
	Budget beds		1	1	1			1			
	Repairs		2		1			1		1	
	Collections	5	3		1	2	4	2	8		10
	Parkhouse				1	1			4	3	1
	Total	**26**	**30**	**20**	**27**	**28**	**30**	**29**	**29**	**36**	**25**



FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is

affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- Strong partnership working between LCH and LTHT
- Skilled staff with comprehensive knowledge of community services available

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Will be managed by the effective admissions and discharge group.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

A pilot of these scheme has already started to run this year and will expand and roll over into next year.

SCHEME NAME :- **Extended Hours for EDAT**	
SCHEME NO	**16b**
RESPONSIBLE GROUP	Adult Integrated Care Programme
ACCOUNTABLE LEAD OFFICER	Diane Boyne**/**Paul Morrin/ Sam Prince/ ASC tbc (Michelle Tynan or Dennis Holmes)
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Extend hours for the Early Discharge Assessment Team (EDAT) based within A&E and assessment floor at St James's Hospital, including 7 day working

The proposal is to enhance the EDAT service that operated successfully over the winter period, including 7 day working, and respond to the outcomes of a recent commissioner-led service review (attached at Appendix 1).

The EDAT service enables patients to be diverted to appropriate community alternatives, reducing admissions and enabling proactive responses to patient's needs, returning patients to a community setting as soon as possible.

The operational hours are currently Monday to Friday 8am – 6pm and weekends 8am – 4pm and staffing is provided in a partnership model with contributions from LTHT, LCH and ASC. Discharge Planning is provided by EDAT to patients in ED, historically approximately 21% of these were discharged within 4 hours, however with the enhanced winter resource this increased to 55%. The remaining 45% were then discharged promptly from CDU and the Acute Floor.

The funding would cover staffing costs within LCH, LTHT and ASC. LCH would act as the lead provider with responsibility for service coordination and delivery against a revised service specification, which is currently under development.

Specifically the funding will support a revised service that will:

- Function 7 days per week covering 0800-2000.
- Focus on patients in the following categories;
    - No admission
    - 0 day admission
    - 1 day admission (overnight)
- Support transfer of care to existing services following these timescales
- Develop KPIs – quantitative and qualitative - to enhance current reporting and demonstrate service impact. This will be supported by identified resource within the LCH performance team and supported by the Adult Business Unit Business Manager.
- Employ a range of additional staff to support the extended opening hours and service focus on 0-1 days. Additional staffing roles will include care management, direct intervention and support functions across the following disciplines:
    - administration

- social work
- therapy
- nursing capacity

- Consideration will be given to skill mix with the introduction of additional non-registered therapist roles and to deployment of resource over the 7 day, 8-20h period to ensure that resources are aligned to demand patterns.
- The additional funding will be delivered within the existing team leadership structure. The team will be managed by the existing B7 Team Manager to ensure delivery against agreed targets and performance indicators. The team manager reports to the Service Manager within LCH and is also supported by a clinical Pathway Lead within LCH.
- Administrative support for the team will enable effective use of clinical time and support communication with patients, families and other departments and collection of relevant data.
- The existing staffing structure is provided at appendix 1 within the review. The additional funding will supplement this structure.
- For indicative purposes the proposed funding will support additional posts, to include the disciplines outlined above, as follows:
  - 1 x administrator,
  - 1 x senior OT,
  - 1 x senior physio,
  - 1 x senior Nurse,
  - 1.5 x senior social worker/joint care manager,
  - 1 x therapy assistant.
- The exact staffing structure will be finalised in discussion between LCH, LTHT, and Adult Social Care to enable effective delivery of the service model outlined above. Commissioners will be updated with the final staffing structure.
- A service specification, reflecting the above proposal has been drafted and will be agreed between LCH and commissioners subject to support for this proposal.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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. The proposal also responds to the outcomes of the Service Review and experience during winter 2013/14.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

All of the key stakeholders will be required to work in an integrated and collaborative way to support delivery of the proposed enhanced service.

This is part of the wider development of integrated neighbourhood health and social care teams and secondary care services.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£300k recurrently in both 2014/15 and 2015/16

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The additional winter resource has enabled the service to increase staffing capacity to provide a 7 day service. On average EDAT have discharged 55% of patients that they were involved in planning a discharge from ED within 4 hours (approx 68 patients a month). The remainder were discharged soon after from CDU or the Acute floor depending on where they were admitted to. Last year, prior to additional resource, EDAT discharged 21% of the patients seen in ED. It is anticipated that EDAT would be able to sustain these levels once the additional resource identified has been secured.

As noted in the EDAT review, further work is required to develop effective measurement of impact of EDAT. This work will be led by the EDAT team manager, supported by dedicated performance resource, as part of the implmeentaiton of the enhanced service..

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The following performance measures have been proposed. The lead provider will work with other providers to ensure provision of the required information. As a number of measures are new or developmental, performance management resource will be secured to support development and delivery against the KPI schedule. The lead provider will work with providers and commissioners to confirm the KPIs and develop mutually agreeable indicators, baseline position and thresholds during Q2. It is anticipated that some indicators will be measured at service level, whilst others will be addressed at system level.

Proposed indicators

Performance Indicator	*Indicator*	*Threshold*	*Frequency of Monitoring*
Quality/Outcomes			
Patients are discharged safely to an appropriate community setting	% of patients re-admitted within 30 days		Quarterly
Performance/Productivity			
Patients selected for admission avoidance pathways are discharged from ED within 4 hours	% of patients	95%	Quarterly
Patients selected for EDAT admission avoidance pathways are discharged within 24 hours	% of patients	100%	Quarterly
Number and % of patients screened by source within agreed timescale: • ED • PCAL • CDU			Quarterly
Number and % of patients identified for admission avoidance pathway by source: • ED • PCAL			Quarterly

• CDU			
Number of patients discharged by source within agreed timescales: • From ED • Via PCAL • From CDU			Quarterly
Destination on discharge (by source): • Home no extra support • Home with reablement • Home with an initial package • Home with increased support • Home with ICT • CIC bed • CICU • Emergency respite care • Other			Quarterly
Number of patients identified for admission avoidance but no capacity by source (reason for delay): • From ED • Via PCAL • From CDU • From Acute Floor – by ward			Quarterly
Qualitative data/information - to be developed			Quarterly
Non-availability of service with reasons, including staffing	Number of occasions		

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- The EDAT service is interdependent on a number of other services across the system for maximum effectiveness e.g. community beds, availability of reablement, home care, geriatrician input in ED. Some of these areas are covered in other BCF submissions or in resilience planning currently underway.
- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts/backfill.
- There is a risk that some GP practices will not 'buy in' to the model and may be resistant to adopting it.

- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal.
- The benefits stated are based on estimate/prediction rather than actual.
- The ability to track patients through the system. This will be mitigated by the use of CareTrak reports.
- Ability to specifically attribute savings to these proposals as opposed to savings in system per se.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

Scheme to commence in 2014/15 and continue on in 2015/16

SCHEME NAME :- Enhancing Integrated Neighbourhood Teams (Discharge Facilitators)	
SCHEME NO	**16 c**
RESPONSIBLE GROUP	**LTC, Dementia, EOL, Frail Elderly Programme, Diane Boyne**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	**Emma Fraser**
VERSION & DATE	**V0.3 12/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

The Discharge Facilitator roles provide a link between hospital and community services ensuring smooth transfer of care. Through active case management of patients using clinical skills and extensive working knowledge of community services, Discharge Facilitators support patients who are ready to be discharged. This direct link and strong communication with wards ensures timely discharge of patients.

The proposal is to increase the number of discharge facilitators to 5 WTE, to focus on end of life (EoL) patients and those leaving medicine/elderly wards. This proposal builds on the positive outcomes to date from existing 2 WTE EoL discharge facilitator roles, and the service for medicine/elderly wards that was put in place over winter 2013/14.

The existing EoL 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 WTE additional discharge facilitators put in place over the winter targeted 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 and received positive feedback across the system based on their impact on improving flows and managing effective discharge.

Additional staff to support the extended opening hours and expanded coverage will be recruited. The current planning assumption is that we will increase discharge facilitators by 5.2 WTE. (currently have 2 WTE EoL discharge facilitators permanently in post.) The bid is based on indicative costings for 1 B7 clinical team leader, 2 WTE B6 equivalent (nurse/therapist/Social worker), 2 WTE B5 equivalent, 0.2 B3 admin, plus associated oncosts for weekend working/overheads.

The proposal will provide additional capacity which will enable the service to

- provide increased coverage
- provide a service over 7 days 08:30-16:30.
- Focus on patients in the following categories:
    - Medicine/elderly wards
    - End Of Life
- Support transfer of care to community services in accordance with patient's personalised care plan
- Develop KPIs – quantitative and qualitative - to enhance current reporting and demonstrate service impact. This will be supported by identified performance resource within LCH

The service delivery model will be amended to integrate all the discharge facilitators (currently separate functions covering EOL and Medicine & Elderly) into one discharge facilitation team over the next few months to provide an effective 7 day service with associated leadership and admin support to provide a service across EoL and medical/elderly patients. As part of this bringing together there may be some further amendments to skill mix/staffing and we will keep you updated once a final staffing structure is agreed for the new team.

The LCH Discharge Facilitator Team (covering EoL and Medicine/Elderly wards) will work with LTHT's discharge team (which provides support across LTHT) and with the Early Discharge Assessment Team (EDAT) (which focuses on 0-1 days) to ensure coordinated processes.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Commissioning - LSE CGG
Provider -LCH

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

- The enhanced discharge facilitator team will improve flow from acute settings to reduce length of stay and delayed transfers of care and builds on the successful model in place. This will contribute overall to reducing acute activity and costs within the system.
- 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/facilitate Preferred Place of Care(PPC)/Preferred Place of Death (PPD) at End of Life
- Improve the efficiency of the integrated neighbourhood teams by reducing the amount of time taken post discharge which is currently spent dealing with issues.

The key metrics to be used to monitor the impact of this scheme are;

- Number of discharges facilitated
- Time from referral to discharge.
- Number of discharge planning meetings attended / month.
- Number of discharge related incidents
- Patient satisfaction/patients achieving PPC/PPD

- Length of stay / delayed transfers of care – system measures

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£260k FYE (clinical resources)

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

All of the key stakeholders will be required to work in an integrated and collaborative way to support delivery of the proposed enhanced service. The key stakeholders are Leeds Community Healthcare Trust (LCH) as the provider and Leeds Teaching Hospital Trust (LTHT) – a strong interface is essential for the success of this scheme.This scheme is part of the wider development of integrated neighbourhood health and social care teams and secondary care services.

Activity (what reductions in relevant activity will the proposal have expressed as numbers of people/% of current activity levels?)

There will be an increase in the number of people managed through this service. An indicative number of referrals for the revised service per annum would be a 150% increase in referral and activity levels. Historical data for this service is limited and as outlined above, further work is required to develop effective measurement of the impact of the redesigned Discharge Facilitator Team. This work will be led by the service team, supported by dedicated performance resource from LCH, as part of the implementation of this enhanced service providing an improved baseline, performance indicators and thresholds for future performance management.

Cost

As described in the introduction this proposal will positively impact on patient flow and overall system performance. Work is being undertaken to determine the planned cost impact at a whole system level.

The scheme proposes creating new discharge facilitation roles that will work with elderly patients to ensure timely discharge. The existing service will be scaled up by 5.2 WTE to work with the existing teams to reduce excess bed days on general medicine by 50%.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*

- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

- Strong partnership working between LCH and LTHT
- Skilled staff with comprehensive knowledge of community services available

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- The success of the discharge facilitators is dependent on ongoing strong partnership working with staff at Leeds Teaching Hospitals Trust
- Ability to specifically attribute savings to these proposals as opposed to savings in the system per se.

Total impact of all proposed changes is not fully modelled or known at this time,

though work is underway. (Whole system risk).
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
The scheme will be implemented by Q3 2014/15

SCHEME NAME :- **Enhancing Integrated Neighbourhood Teams**	
SCHEME NO	**16d & 16g**
RESPONSIBLE GROUP	Adult Integrated Care Programme
ACCOUNTABLE LEAD OFFICER	Diane Boyne**/**Paul Morrin/ Sam Prince/ ASC tbc (Michelle Tynan or Dennis Holmes)
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

More specifically this will include:

d) Extend the home care service to support 24/7 support for service users.
Extend the home care service capacity to enable more people to be cared for in their own home 7 days a week and provide new packages of care at weekends and late evenings.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Leeds community Healthcare and Leeds Teaching Hospitals NHS Trust

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Quantitative measures will include measuring changes in:

- hospital activity (Inpatient, Outpatient and A&E)
- primary care activity
- community services activity (health and social care)
- Pharmacy costs
- Delayed transfers of care
- Readmission rates

Qualitative measures will include

- EQ5D
- Goal Attainment tools
- Patient Stories and satisfaction tools

In addition specific metrics can be developed for each proposal e.g. LCES KPIs.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

Costs for scheme 16d are still be calculated. Initial calculations indicate that £750k will be required.

Costs for scheme 16g are £200k recurrently for both years.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Extending access to home care packages into the evening and over weekends is anticipated to facilitate earlier discharge of patients, helping reduce DToC. Currently DToC due to delays associated with accessing home care packages accounts for around 125 lost bed days per month. Whilst this additional capacity is unlikely to eliminate these delays, we expect the extra capacity to reduce delays by 20% for this cohort.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an “Outcomes Based Accountability” (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an

individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Currently being worked up between now and December 2014.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts/backfill.
- There is a risk that some GP practices will not 'buy in' to the model and may be resistant to adopting it.
- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal. Benefits stated are based on estimate/prediction rather than actuals.
- Ability to specifically attribute savings to these proposals as opposed to savings in systems.

whole system risk. Total impact of all proposed changes is not fully modelled or known.
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
For 16d the scheme is likely to start in April 2015. For 16g it has commenced this year and will roll over into 2015/16.

SCHEME NAME :- Enhancing Integrated Neighbourhood Teams (Better me Programme)Discharge	
SCHEME NO	**16e**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	**Andy Harris/Ian Cameron**
BUSINESS CASE AUTHOR/S	**Diane Boyne**
VERSION & DATE	**V0.3, 12/09/14**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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 re-aliment. 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.

Context

This proposal aims to complement and build up on existing good practice within the city – e.g. identification of patients at risk, integrated working, supported self-management and by taking evidence from elsewhere in the country and developing a Leeds based model that is clinically led, responsive and effective. The approach outlined aims to empower patients to self-care and manage and reduce ongoing/long term requirement for input from statutory services.

The outlined proposal is informed by early adopter work done locally in 2 practices in the West of the city (process for selection previously agreed with the 3 CCG's). Securing additional funding through this bid would allow for share and spread at scale to maximise impact across the whole system alongside further opportunity to test and refine the model at the local level. Additional resource (clinical staff) would be required to roll out the model further. The impact of the additional investment would be monitored over and above the core service offer to clearly articulate the return on investment made.

The recent changes to the GP contract (Proactive Management) provide a clear link to this proposal which would provide the additional resource required in the system to effectively manage relevant patients identified on practice 2% lists through engagement with the programme.

Programme Delivery

Patients for the programme would be selected through a number of routes e.g. use of the Risk Stratification Tool, MDT discussion, Case Management meeting.

From available evidence the most appropriate patients would be in the lower end of the top 2% and the higher end of the medium risk category. This would then allow for the programme to demonstrate if successful impact on regression to the mean.

- Following initial assessment and patient consent, through discussion with the MDT a goal centred plan of care would be agreed between the patient and relevant professionals
- Based on evidence from elsewhere and here in Leeds the plan would be delivered over an 8-12 week period
- As part of the plan a key worker would oversee delivery which would involve a range of personnel including Health Trainers/Voluntary Sector providers
- Based on goals identified at the conclusion of the programme the aim would be that the patient should have achieved their goals and have the tools, skills and confidence to continue to self-manage on an ongoing basis
- The plan would be to monitor progress/impact over the longer term for each patient successfully exiting the programme
- From available evidence it is clear that the programme is a powerful way of making a difference to things important to the patient and is consequently more sustainable in the long term.

Strategic Fit

This proposal fits with the national and local agenda to improve care for people with long term conditions by taking a much more proactive approach with a focus on patient's identified goals.

The Better Me Programme would be one element of anticipatory care within the city and would link the Year of Care work stream. The initiative also supports the national Pioneer work in enabling the city to go further and faster in terms of impact.

Proof of Concept

A small successful trial with 2 GP practices has just been completed (see Appendix 1 for the full evaluation report). This demonstrates the clear added value of the programme. The GPs involved also evaluated the programme positively for patients.

Scaling up

A process of wider testing is proposed in Quarter 3/4 2014/15 with the programme being rolled out to a further 30 GP practices across the city. The roll out and delivery of this programme will be delivered through the additional resource requested in partnerships within the Neighbourhood Teams. Spread to the remaining practices within the city would be anticipated in Q1/Q2.

The plan would be for two implementation co-ordinators to start in post at the beginning of July 14 to take forward implementation. They will be the link to identified practices and will continue to develop and refine the 'offer' The project team will ensure there is a robust workforce plan to support the timely recruitment of staff and also support development of existing staff where required. Work is underway to ensure the right HR capacity is in place to manage the recruitment process required.

Following the trial evaluation further work is required as part of the next stage of the planning to determine the exact team size and skill mix required. This will be managed against the back drop of

the existing community nursing and therapy services undergoing considerably change as part of the Integration Programme; the delivery of the TOM will result in changes to the existing workforce.

The learning and experience from the wider testing will be then used to refine the model before it is rolled out to the remaining practices from Quarter 1 2015/16.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Commissioner – LSE CGG
Provider – LCH / LCC ASC

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

<u>Evidence of Need and Effectiveness</u>

The evidence of patients identified through the risk management tool is that there is no systematic programme of support and intervention offered to maximise their independence and self-care. The result is that across the city we are not maximising our opportunities to change patient behaviour and subsequent demand for services.

Models similar to the bid outlined have been developed and tested elsewhere in the country and have been shown:

- Improved patient and carer experience and satisfaction
- Improved quality of life and ability to self-care
- Significant contribution to savings across the system

The proposals outlined above will expand capacity in integrated neighbourhood teams to work with primary care 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.

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.

Historically Leeds has not had in place a systematic model to proactively manage patients identified as being at risk with a view of reducing dependence on statutory services.

This proposal aims to fill this gap by offering a city wide programme to all appropriately identified patients as an addition to the core neighbourhood team service offer.

The programme would aim to focus on patients with long term conditions and be delivered through a coproduced goal centred personal plan of care aimed at increasing personal confidence and ability to self-care/manage.

The programme would offer a further option within the menu of options that GP's and integrated teams can access to manage patients appropriately at the neighbourhood level.

Quantitative measures will include measuring changes in:

- hospital activity (Inpatient, Outpatient and A&E)
- primary care activity
- community services activity (health and social care)
- Pharmacy costs
- Delayed transfers of care
- Readmission rates

Qualitative measures will include

- Goal Attainment tools (GAS, TOM)
- Patient Stories and satisfaction tools

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£1.5m FYE (clinical resources)

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*

- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

All of the key stakeholders will be required to work in an integrated and collaborative way centred on the patient and their personalised care plan.

The neighbourhood teams – notably community nursing, therapy and social work staff, primary care, Health Trainers, specialist services, voluntary sector organisations This is part of the wider development of integrated health and social care teams which requires significant changes in the way that teams are configured and work.

Secondary care services – particularly in relation to interface functions e.g. discharge planning.

Activity Impact

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 750-1200

Early results from the small scale trial conducted in Leeds in 2014 showed the trial was successful:

- Ten of the twelve patients completed the programme
- Average **12.6%** increase in reported health (EQ5D)
- Average increase of **14.9** of their Goal Attainment Score.
- Six patients who scored as moderate/high risk of falls at the start of the programme all had **improved** scores at the end of the programme.
- Two patients have had their predicted risk level **reduced** [based on Risk Stratification data as at 3-4 months post-trial]
- Average reduction of **2.4** GP visits [based on Risk Stratification data as at 3-4 months post-trial]

Cost (where and how much cost would you expect to save from this proposal based upon the reductions in activity levels assumed?)

Implementation of a proactive care programme in Kent achieved savings of £1,000 per patient that successfully went through the programme. This figure is one we aim to replicate in Leeds.

Early results from the small scale trial conducted in Leeds in 2014 showed an average reduction of £410 [based on Risk Stratification data as at 3-4 months post-trial] per person for the 3-4mth period.

The activity levels detailed above should translate into cost savings. This will need to be managed across the whole system due to the interdependency of key proposals.

BCF National conditions

- **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 the Transformation Board.
- **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
- **7 day services to support discharge and reduce admissions.** Many of the schemes included in the Enhanced Neighbourhood Team proposal specifically increase capacity at weekends and out of hours to support timely discharge and reduce risk of admission.
- **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 the different organisations. This work is support by on-going developments in information governance and data sharing between health and social care organisations in Leeds, lined to pioneer status and Leeds Care Record.
- **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.
- **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, community based response. The overall impact and management of this will have to be monitored closely between commissioners and providers.

BCF Performance Targets

- **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.
- **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.
- **Delayed transfers of care from hospital per 100,000 population.** The discharge facilitator capacity will improve flow from acute to community settings reducing DTOC. The increase in community nursing will also support more timely discharge.
- **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.
- **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. More people will be able to die at home with the increased capacity in community nursing.

Estimated diagnosis rate for people with dementia – Proactive Care may identify patients not currently diagnosed with dementia who are exhibiting early symptoms.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Key Success Factors include:

- Resource availability including health trainers and voluntary sector
- Training for resources in motivational interviewing/health coaching/patient activation
- 'Buy-in' from GP practices

Implementation Approach:

Wider Testing – Q3/4 2014-2015

The wider testing phase will run the programme in 30 GP practices across the city (approximately a quarter of practices). The practices are in the process of being agreed but will include some who already have a Health Trainer working with them as well as those who had aligned LCH staff attend a Health Coaching Training course in June 2014.

In Q3, learning and experience from the trial will be used to drive an analysis phase followed by solution design and development phases during which the programme and methodology will be reviewed and refined before testing the revised programme with the 30 GP practices in Q4.

Phase 1 Implementation – Q1 2015-2016

Learning and experience from the wider testing will be used to further review and refine the model before it is rolled out to a further 30 GP practices across the city (approximately half the practices)

Phase 2 Implementation – Citywide from Q2 2015-2016

Learning and experience from the Phase 1 implementation testing will be used to further review and refine the model before it is rolled out to the remaining GP practices across the city.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

To Proposal,

- Any delay in contribution of funding will impact on roll out/scaling up across the city and impact seen within this financial year
- This initiative is a key enabler to support practices with their 2% list and the new work that is generated through this without the additional investment the capacity and ability of community services to work with practices to deliver this GP contract change would be severely compromised
- There are other projects/initiatives working on related areas or with the same services – i.e. Integration (Neighbourhood Teams, Case Management), Neighbourhood Team Co-ordinators, Early Discharge, Self-Management. There is a risk that work could be duplicated or not cohesive unless scope and interdependencies are established
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts/backfill.
- There is a risk that some GP practices will not 'buy in' to the model and may be resistant to adopting it.

- The timescales do not allow for long term analysis of the initial trial or test phase results before full implementation for some elements of this proposal.
- The benefits stated are based on estimate/prediction rather than actual.
- The ability to track patients through the system. This will be mitigated initially by the use of the Risk Stratification tool with ongoing investigation into long term adoption of other possible tools i.e. CareTrak reports.
- Ability to specifically attribute savings to these proposals as opposed to savings in system per se.

To whole system,

- Whole system risk - impact of all proposed changes is not fully modelled or known at this time. Need to work closely to develop agreed indicators and processes to monitor the programme.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

The Better For Me project is being managed in accordance with the Leeds Community Healthcare NHS Trust Programme Management Office Project Lifecycle and follows 8 project stages:

Project Stage / Milestone	Estimated Completion Date
1. Idea	11/12/13
2. Initiation	30/05/14
'Proof of Concept' Trial	30/05/14
3. Analysis	27/06/14
4. Solution Design	01/08/14
5. Development inc. Communications & Training plans	28/11/14
6. Testing	27/03/15
7a. Phase 1 Implementation	26/06/15
7b. Phase 2 Implementation	25/09/15
8. Closure	06/11/15
9. Post Project Review	25/03/16

SCHEME NAME :- Enhancing Integrated Neighbourhood Teams (Increased Community Nursing Capacity to support care at End of Life and 7 day working)enhance 7 day working	
SCHEME NO	**16f**
RESPONSIBLE GROUP	**TBC** **Brian Collier (Transformation Director)** **Mark Hindmarsh (interim project manager)**
ACCOUNTABLE LEAD OFFICER	CCG - Andy Harris/Ian Cameron;
BUSINESS CASE AUTHOR/S	**Emma Fraser**
VERSION & DATE	**V0.3, 12/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :

Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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.

This proposal is to increase the capacity in the community nursing service at a neighbourhood level (with a specific focus on district nursing services) supporting improved care for End Of Life (EOL) patients and 7 day working.

The service model for this proposal is to deliver the additional capacity to support the above areas within the developing Integrated Neighbourhood Teams (INT). Thirteen INTs are under development providing nursing, therapy and social work input at neighbourhood level, wrapped around GP practices. The additional posts will join the INTs and be managed within the INT leadership and management structure, ensuring that the additional capacity has maximum impact on patient care.

It is anticpated that the proposed funding will support additional posts as follows:

- 2.4 wte x administrators
- 23.5 wte community nurses

The exact staffing structure will be finalised as part of ongoing work to develop integrated neighbourhood teams. Commissioners will be kept up to date with changes to the planned staffing structure.

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Commissioner – LSE CCG
Provider - LCH

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

This proposal will expand capacity in integrated neighbourhood teams in order to work with primary care to:

- proactively manage people to live independently at home, reducing admissions and readmissions
- improve flow from acute settings to reduce length of stay and delayed transfers of care
- improve performance in meeting people's health needs as they approach the end of life

This increase in community nursing capacity will improve 7 day working and flow within the service.

The End of Life Health Needs Assessment (HNA) undertaken recently in the city recognised the current need to increase District Nursing capacity to deliver all aspects of end of life care. This includes capacity to manage the increased number of people approaching end of life and choosing to be cared for and die in their usual place of residence

To date there has been a reduction in the number of people dying in hospital nationally and in Leeds. Leeds ONS data referred to in the HNA shows a decrease in hospital deaths from 50.2% in 2007 to 48% in 2011. Deaths at home have increased from 19% to 21% over the same period.Increasing capacity within neighbourhood teams should enable this figure to continue rising.

This increased capacity will also enable the service to better support the earlier discharge of all patients and prevent admissions through proactive management. This will contribute overall to reducing acute activity and costs within the system
.

The key metrics that will be used to evaluate the impact and success of this scheme are;

- Patient satisfaction measures to be developed in line with the city wide work plan for End of Life care
- Improved adherence to Service Delivery Framework for End of Life Care, including bereavement support
- Increase the numbers of Independent Nurse Prescribers within neighbourhood teams actively prescribing for patients approaching end of life.
- Increase the number of nurses who can verify expected death within neighbourhood teams.
- Maintain current PPD target for an increasing number of End of Life Care patients cared for in usual place of residence
- On going review of citywide EoLC data collated by the CCGs from 2014/15 Q1 in line with HNA recommendations

During Q2 2014/15 Leeds Community Healthcare Trust will develop key metrics and baselines for the above indicators as the service model develops, in conjunction with commissioners.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

1.2m FYE (clinical resources and associate non pay costs)

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*

- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

All of the key stakeholders will be required to work in an integrated and collaborative way centred on the patient and their personalised care plan, in particular improving coordination of care for patients approaching end of life. The effective and consistent use of EPaCCS and implementation of the Leeds Care Record is critical to this.

A key relationship is between the acute hospital services and LCH – particularly in relation to the interface functions e.g. discharge planning

Neighbourhood teams are in the process of being established - this is part of the neighbourhood team offer and will be delivered as part of the Integrated Neighbourhood team.

Activity (what reductions in relevant activity will the proposal have expressed as numbers of people/% of current activity levels?)

- Estimated total additional activity for the additional resource would be c35,000 contacts (FYE), depending on the final service delivery model agreed. This increase in activity in the community should result in stopping people going to hospital unnecessarily and improving the patients experience.
- The proposals will improve other aspects of quality:
    - providing more early support to patients recognised as palliative;
    - potentially improving symptom control by increasing the numbers of Independent Nurse Prescribers actively prescribing for patients approaching end of life;
    - reducing the need for GP visits in and out of hours through this increased prescribing and more nurses being trained to verify expected death.

Increasing nursing capacity in the community is expected to allow between 300 and 500 more patients each year to choose to die at home rather than in hospital. Using NICE System Impact Modelling End of Life Tool, this additional support is expected to avoid 337 non-elective admissions. This figure is consistent with local intelligence for the opportunity saving associated with avoided non-elective admissions.

For illustrative purposes
The range of possible contacts is:

Minimum - 22,500 (based on x 1 daily contact for 1 month at intermediate stage and x 2 daily contacts for 1 week at intensive stage).
Maximum - 112,000 (based on x 1 daily contact for 3 months at intermediate stage and x 3 daily contacts for 2 weeks at intensive stage).
and obviously a whole range in between! There are a whole load of variables within that range.
This is based on an assumption of 500 patients a year.

Based on the investment proposed and using current average number of contacts per WTE based on the current contract for DN -24 services.
The proposed investment buys 23.5 WTE clinical staff (based on B5). we know that in reality we are likely to further skill mix this to provide best overall skill mix in developing Integrated Neighbourhood Teams. Working on assumption of 23.5 WTE the revised proposed total increase in F2F contacts would be in the region of 35-40,000.
For illustrative purposes this could be broken down as follows:

1 month x1 contact daily (15,500 contacts) +2 weeks x 2 daily contact (14,000 contacts) + 4 days x 3 daily contacts (6,000 contacts) = 35,500 contacts
If additional contacts were required (nearer the 50,000 level), additional investment would be required accordingly to increase the WTE capacity available.

COST

The cost benefit analysis will need to be undertaken with commissioners as part of the wider system planning linked to the Transformation Programme.

BCF IMPACT

BCF National conditions

- **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 the Transformation Board.
- **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
- **7 day services to support discharge and reduce admissions.** Many of the schemes included in the Enhanced Neighbourhood Team proposal specifically increase capacity at weekends and out of hours to support timely discharge and reduce risk of admission.
- **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 the different organisations. This work is support by on-going developments in information governance and data sharing between health and social care organisations in Leeds, lined to pioneer status and Leeds Care Record.
- **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.
- **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, community based response. The overall impact and management of this will have to be monitored closely between commissioners and providers.

BCF Performance Targets

- **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.
- **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.
- **Delayed transfers of care from hospital per 100,000 population.** The discharge facilitator capacity will improve flow from acute to community settings reducing DTOC. The increase in community nursing will also support more timely discharge.
- **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.
- **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. More people will be able to die at home with the increased capacity in community nursing.

Estimated diagnosis rate for people with dementia – Proactive Care may identify patients not currently diagnosed with dementia who are exhibiting early symptoms.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges

that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

Successful recruitment of the community nurses

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

- A lot of change is being undertaken at the same time within community nursing and the neighbourhood teams - interdependencies with this work.
- Workforce supply – there is a risk that resource numbers and skill sets required to implement and run the model across the city will not be available to fill posts. This is being mitigated by increased recruitment resources and staff being recruited on a permanent contracts (risk to be shared with commissioners).
- The benefits stated are based on estimate/prediction further work is required over the coming months across the system to finalise the benefits.
- An increase in the numbers of patients approaching end of life being supported by integrated neighbourhood teams is dependent on earlier identification and referral of patients by other services
- Ability to specifically attribute savings to these proposals as opposed to savings in system per se

- Whole system risk. Total impact of proposed changes is not fully modelled or known at this time.

PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
It is planned that this scheme/additional capacity will be in place by the beginning of Quarter 3 2014/15

SCHEME NAME :- Frequent Flyers	
SCHEME NO	**17a**
RESPONSIBLE GROUP	**Debra Taylor Tate**
ACCOUNTABLE LEAD OFFICER	**Nigel Gray / Jason Broch**
BUSINESS CASE AUTHOR/S	**Matt Storey**
VERSION & DATE	**1.0 10/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

Working from the point that frequent users of urgent care services are either frequently ill or are using Urgent Care services frequently due to disengagement with other more appropriate services, it becomes clear that urgent care usage is a symptom of a larger problem rather than a problem in itself.
More robust multi-agency case management will allow this cohort of service users to achieve better outcomes, which will be reflected in their decreased use of Urgent Care services.

This contributes towards the BCF national conditions of data sharing and use of NHS number and Joint care assessments, as well as contributing towards the aim of reducing emergency admissions by 3.5%, reducing delayed transfers of care, and improving Patient and service-user experience. At a local level this scheme also contributes to HWB targets 1 – 4 (People will live longer and have healthier lives; People will live full, active and independent lives; People will enjoy the best possible quality of life; People are involved in decisions made about them)

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

To ensure best use of resources it is proposed that this resource is used to commission a case management coordinator from a third party organisation that already has the appropriate information governance arrangements in place with the necessary stakeholders (see below)

This scheme will target individual high volume users of urgent care services for whatever reason. Exact thresholds are yet to be defined but the case management coordinator will work with the CCG and providers to target those where the highest system benefit will be realised. The coordinator will work across all urgent care providers in Leeds to map the service usage of individuals in order to ensure that the most appropriate individuals are targetted

Projected volumes of service users are difficult to calculate. In a snapshot assessment it was found that the 5 highest users of ED services at LTHT accounted for over 500 attendances per month. It is

nationally recognised that these high volume service users tend to use services intensively for a short time, then they are replaced by another high volume service user. It is therefore anticipated that the workload for this post will continue as new patients present to the system.

LNCCG will identify who this service is to be commissioned from. Likely partners may include LYPFT or West Yorkshire –Finding Independence (WY-FI), who both have established multi-agency working procedures and extensive case management experience

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The Urgent Care team (based at LNCCG) will deliver the initial business plan and service spec, and then commission and monitor delivery of this scheme on behalf of the city
The provider organisation will be responsible for delivering the multi-agency case management. We are cogniscent of the challenges that the very high volume service users present, and that this may make case management extremely challenging. It should therefore be explicitly recognised that - in the pilot phase – patient outcomes will be monitored but not commissioned as a KPI.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

A snapshot of A&E data indicates that 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

Multiple research papers indicate that a case management approach can help reduce attendances in this group by between 30-70%, resulting in a drop in overall A&E attendances of between 1 and 2 % (2000-4000 attendances, circa £200,000-£400,000 cost saving based on average A&E tariff), with similarly reduced admission rates and impact on other services. Once this is expanded to include lower volume frequent service users and frequent users of other services it is clear that this post has the possibility of significantly improving individual's outcomes, and thus creating

significant system efficiencies.

Key Metrics Required,
Presentations to urgent care (by user)
Tariff applied to each presentation
Outcome of each presentation
Total financial cost of each presentation
Level of intervention by other services (Social Services, Council, Police etc)

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

Key investment is to fund a project manager to establish the Data Sharing and Data Management Agreement between providers, and to then provide the ongoing coordination and support of the multiagency process. It is anticipated that this could be a Band 5 Project Support role at a cost of £27,901, supported by a band 3 admin assistant at a cost of £19,268

Total projected staffing cost : £47169

SystmOne Setup & licence for 1yr : circa £30,000

Total costs (est) : £77,169

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Multiagency cooperation between all health and non-health agencies will have to be assured to ensure that care plans are appropriate to the stated aims, and are applied consistently. It is anticipated that input will be needed from
LTHT
LCH
YAS (111 & 999)
LCD
Malling Health (provider of WiC services at The Shakespeare Medical Centre)
Adult Social Care

Leeds Addiction Unit
LYPFT
Dial House
Volition
Leeds City Council
West Yorkshire Police

Plus other agencies (for example third sector organisations) as required on a case-by-case basis

Activity,

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 activity of 3.15% of total demand . Assuming 250 of these presentations also involve ambulance use this equates to 2.67% of YAS 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 to the top 5 attenders at LTHT
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.
If benefits can be realised it is possible that this scheme in isolation could deliver a significant reduction in ED admissions, possibly totalling or exceeding the 3.5% reduction required (approximately 2454 ED admissions, but more if non-elective admissions direct to assessment units/wards are taken into consideration)

COST

It is key to understand that some of the projected savings may not be fully recouped, in that the savings made may be absorbed into improving normal service delivery, and funding may have to be redirected for individuals to deliver more appropriate treatments/interventions

Provider (Service)	Episodes p/a	Indicative Cost (average)/£	Total Saving/ £
LTHT(ED)	6000	100	600,000
YAS(999)	3000	227.66	682,980
LTHT (Short Stay admission)	600	694	416,400
			1,699,380

As with activity it is difficult to provide any solid figures for costs reduction as there are viable reasons why no impact may be seen, and equally the figures may be significantly above those quoted when the wider population is considered

On BCF,
No negative outcomes predicted. Potential positive outcomes against emergency admissions targets.

FEEDBACK LOOP
What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

As previously mentioned, due to the challenges these individuals present, no change in service usage may be seen. Therefore the contractual measures used for the scheme will be agreed milestones between the service provider and the CCG for the establishment of the Case Management process. Individuals' service usage is readily available from Business Intelligence colleagues (CCG and provider) through existing arrangements and should provide the baseline for impact measurement. It is not practicable or ethical to establish a control group due to the number of variables that influence service use. However it may be possible to use the service usage of individuals who opt out of the process to compare service use trends.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The service spec for the provider organisation should establish that they have established skills, links and data sharing agreements with the necessary partners (including service users) in order for this to be a success. They will also have to demonstrate that they have responsive and easily replicable IG arrangements in place in order to robustly establish any new links that may develop during the course of the programme.
It is projected that service spec will take 1 month to draw up, a further month to then identify our preferred provider, and a further 2 months for recruitment and selection, with staff therefore starting in post 4 months after scheme approval

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Agencies (especially non-health) not engaging in process

- Failure to agree a data sharing or data management agreement
- Agreed care/intervention plans not followed
- Difficulties funding different interventions, especially if it means redirecting funding from one provider to another

- Reported performance may be negatively affected as the management of these high volume patients may positively contribute to performance figures

PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
Realistically we would aim for the project to start in April 2015 with the pilot to run through a full financial year. This may be accelerated if funding has to be realised in this financial year. Once this scheme is approved the Urgent Care Team can draw up a full business case and service spec within 1 month, with further development work to take place in partnership with the provider.

SCHEME NAME	**Community Pharmacist Minor Ailments scheme**
SCHEME NO	**17b**
RESPONSIBLE GROUP	**Strategic Urgent Care Board**
ACCOUNTABLE LEAD OFFICER	**Nigel Gray**
BUSINESS CASE AUTHOR/S	**Debra Taylor-Tate**
VERSION & DATE	**Version 2, 9 Sept 2014**

STRATEGIC OBJECTIVE OF THE SCHEME :

The transformation of urgent care services in line with the national review.

OVERVIEW OF THE SCHEME

The Pharmacy First service is a locally tailored scheme where patients are encouraged to consult a participating community pharmacy, rather than accessing their GP or urgent care, for a defined list of common ailments. The pharmacist will give advice and supply medication from an agreed formulary, or refer the patient to the GP if necessary.

If patients are exempt from NHS prescription charges, medicines are supplied free of charge. Therefore, the payment barrier, which can prevent patients choosing to see a pharmacist instead of their GP or accessing urgent care, is removed. If the scheme is also open to patients who normally pay prescription charges, they will pay a prescription charge for each medicine supplied.

Minor ailment schemes benefit patients, since they receive quick expert advice in the pharmacy without the need to make an appointment with their GP or Local Care Direct. This will hopefully allow GPs to spend more time focusing on those patients that really need their input, managing long term conditions and improving access. This will have a beneficial impact on both GP access and reduce the burden on urgent care. In addition, such schemes promote the role of the community pharmacist as a medicines expert to patients, practice staff, GPs and other health care professionals.

THE DELIVERY CHAIN

The service will be provided across Leeds through Community Pharmacy West Yorkshire (CPWY). Services will be delivered by individual pharmacy organisations governed by CPWY. Leeds North will be the lead commissioner as host of Urgent and emergency services

THE EVIDENCE BASE

This service has been running since January in NHS Bradford City CCG. A three month evaluation has just been completed and shows:

Overall, in the first 3 months, Pharmacy First scheme has shown to be a cost-effective way to manage patients presenting with minor ailments. A high number of consultations for minor ailments were delivered through this service with the estimated release of over 1825 GP consultations. Diverted A&E and walk-in consultations have already saved £2115. Most of the patients were under 10 years old

with over half of those being under 5 years.

The majority of patients were treated for self-limiting viral symptoms such as cough, cold, sore throat and fever and were provided with symptomatic relief for their symptoms, keeping them out of a service environment. The cost for medication was low (per patient £1.78 and per item £1.18). Including the service fee of £4.50 this equates to an average consultation cost per patient of £6.28.

INVESTMENT REQUIRED

Funding

Minor Ailment Consultations	12,500	£56,250
Drug Cost	12,500 (Average cost £2)	£25,000
Project management	Implementation and ongoing support	£7,800
Service administration and data collection	£4 per pharmacy per month	£1,920
Total funding		£90,970

IMPACT OF THE SCHEME

Improve access for patients, promote pharmacy as an alternative to GP practice, Out of Hours service and A&E reducing pressure on and cost to the urgent care system by shifting demand to a more appropriate setting.

Benefits of a community pharmacy minor ailments scheme:

- Promotes self-care through pharmacy, educates and empowers patients in caring for themselves
- Provides access for patients to appropriate advice and/or treatment
- Improves primary care capacity by reducing GP practice and OOH services workload related to minor ailments
- Can integrate with NHS111 and Directory of Services to reduce pressure on urgent care and reduce A&E attendances
- Improves access to medicines and increase choice of primary care services
- Improves GP access for patients with more complex conditions
- Promotes better working relationships between community pharmacists and the wider Health Economy

Improvement CCG outcome indicator 4ai (Patient experience of GP services) and indicator 4aii (Patient experience of GP out of hours service) would be expected.

Shift of patients to pharmacy services would provide effective care closer to home where appropriate improving the patient experience and outcome as well as reducing pressure across both the primary care and the acute sector.

FEEDBACK LOOP

-

Pharmacies:

- *Number of pharmacy attendances for minor aliments*
- *Number of patients who would have gone to a GP if no alternative*
- *Patient experience*
- *Number of pharmacy Re attendances*
- *Number of patients referred through 111*

Collected through MDS and patient survey

OOH services

- *Reduction in overall attendances*
- *Reduction in attendances referred by 111*
- *Data collected through contract process*

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- **Shift in patients behavior to self care**
- **Geographical spread of participating pharmacists offering services**
- **Promotion by all health professionals**
- **Effective evaluation and monitoring to inform further commissioning intentions**
- **Integrated in the 111 DOS, YAS pathfinder**

KEY RISKS

- This funding is only available for delivery of the service 14/15 which may make it difficult to recruit pharmacies as there is limited time to have a return on investment
- Short delivery period will make patient awareness difficult and just as patients become used to the service it may not be recommissioned
- Controls will be required in the service to ensure that spend does not exceed budget. This will be supported by Community Pharmacy West Yorkshire

These risk have been successfully mitigated during the implementation of this service currently running in West Yorkshire.

PROPOSAL IMPLEMENTATION PLAN

-

- *Quarter 3 2014/15 expressions of interest, service specification, contract*
- *Quarter 3/4 evaluation*
- *Quarter 4 future commissioning decision to continue project*

SCHEME NAME	**Improved Information Governance**
SCHEME NO	**18a**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

-Maximising the use of new technologies that identify risk, integrate care records and support self-care [5 Year Strategy].
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

To add a dedicated Information Governance management/advisory resource to 'join up ' the organisational information governance arrangements across the city and coordinate joint 'products' that are required for integrated working and improved information sharing.

Starting as temporary resources and making the case for ongoing, recurrent support .

Delivery during 14/15 and interfacing between Health and Social Care.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This extra capacity will be hosted by Leeds North CCG.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*

- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Especially working alongside other Integration Pioneer cities, the need for this expertise is apparent.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£60,000

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The addition of this specialist expertise will assist in 'unblocking' and enabling the sharing of information across health and social care and across other transformation initiatives. This work is an enabler for further transformation.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

The Leeds Informatics Board
City-wide Information Governance network (to be established)

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The current limitations within the Law and H&SC Act
Expertise
Attracting staff if non-recurrent funding continues.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Expertise
Attracting staff if non-recurrent funding position continues.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

1 April 2014 – Secure temporary expertise
Deliver new Information Sharing Agreement (ISAs) between Health and Social Care to support the Leeds Care Record
Establish City-wide Information Governance network
1 October – Make case for recurrent support
Develop/agree a city-wide approach to ISAs

SCHEME NAME	**Improved business intelligence – city wide analytical resource**
SCHEME NO	**18b**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

- We will continue to develop meaningful measures for the systems and the component parts to ensure that we are able to understand the impact of our actions. This will continue to include Outcomes Based Accountability as well as analytical and modelling tools. [5 Year Strategy]
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

To add a dedicated Analytical resource to support the more sophisticated elements of Analytics including Economic Modelling, metrics definitions, Insights and Intelligence, 'tools' that bring together Health and Social care data for joint analysis.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

This extra capacity will be a combination of ring-fenced capacity from existing health and/or social care staff, the use of specialist contractors and service providers.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*

- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Evidenced-based decision making

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£370,000

Seconded staff
Contractors
Licences
Commissioning Support Unit capacity

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

Assessment of the city-wide financial gap
Assessment of the possible impact of transformational scheme
Assessment of the actual impact of transformational scheme
Insights in to opportunities to design new transformational schemes
Tracking of the BCF

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Transformation Board
Transformation Programmes/Projects
The Leeds Informatics Board
City-wide Intelligence Steering Group

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The current limitations within the Law and H&SC Act for data for commissioners
Availability of data
Expertise
Attracting staff if non-recurrent funding continues.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Availability of data
Expertise
Attracting staff if non-recurrent funding position continues.

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

1 April 2014 – Secure temporary expertise
Develop an Economic Model
Develop a H&SC 'dashboard'
Assist transformation programme to select reporting methodology e.g. OBA
Assist transformation programmes to assess scheme impacts
Assist transformation programmes to design metrics
Establish City-wide Intelligence Steering Group

1 October – Make case for recurrent support

SCHEME NAME	**Leeds Care Record (LCR) – go-live phase and further developments**
SCHEME NO	**18c**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

-Maximising use of new technologies [5 Year Strategy]
-Maximising the use of new technologies that identify risk, integrate care records and support self-care [5 Year Strategy]
-Using the latest technology to enable patients to be seen by the right professional at the right time in the right place [5 Year Strategy]
-Using technology enablers to improve patient care and efficiency [5 Year Strategy]
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

Leeds Care Record is a direct patient care facility that provides 'view' access to clinical information from primary and secondary care via a single 'portal'.

This funding is to rapidly roll-out the Leeds Care Record to all GP Practices, LYPFT, LCH and some neighbourhood teams.

It will also improve the functionality of the LCR to enhance the facilities available for integrated care.

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The LCR is a system/service that is developed by Leeds Teaching Hospitals, commissioning by the Leeds Informatics Board.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

There is significant evidence that clinicians accessing information at the earliest and most appropriate point in the patients' pathway will lead to better clinical decisions and lead to reduced inappropriate admissions, duplicated clinical effort, earlier discharges etc.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£450,000

Project Management
Communications and Engagement
Training and awareness
Various technical developments
Service Desk

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

-Better informed patients – obtaining information from their GP rather than contacting the hospital
-Better informed GPs leading to – fewer duplicate tests, better care decisions, fewer admissions
-Improved information for out-of-hospital clinicians – fewer duplicate tests, better prescribing, reduced admissions
-Improved information for hospital clinicians – better prescribing, earlier admission
-Improved neighbourhood teams

Example of financial benefits:-

433 GPs save 1 test per week by having access to improved information = £338,000 per annum
200 out-of hospital clinicians, as above = £156,000

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

Transformation Board
Transformation Programmes/Projects
The Leeds Informatics Board
Leeds Care Record Project Board

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

GP engagement
Understanding of data sharing and consent

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

Confusion on data sharing and consent esp. care.data
Patients opting out of sharing due to poor understanding/poor communication
Lack of GP engagement

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

55 GP Practices live by end-August
100 GP Practices live by end-March
200 out-of hospital clinicians live by end-December

SCHEME NAME	**Programme Management**
SCHEME NO	**18d**
RESPONSIBLE GROUP	**Leeds Informatics Board**
ACCOUNTABLE LEAD OFFICER	**Dr Jason Broch**
BUSINESS CASE AUTHOR/S	**Alastair Cartwright**
VERSION & DATE	**V1 050914**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

-Maximising use of new technologies [5 Year Strategy]
-Maximising the use of new technologies that identify risk, integrate care records and support self-care [5 Year Strategy]
-Using the latest technology to enable patients to be seen by the right professional at the right time in the right place [5 Year Strategy]
-Using technology enablers to improve patient care and efficiency [5 Year Strategy]
-Supporting Integrated Care
-Supporting/enabling 'transformation'

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

Above and beyond the Leeds Care Record, there are a number of technology improvement initiatives taking place in the city that form part of the Leeds Informatics Board portfolio. This funding allows for:

- Administration of the Leeds Informatics Board
- Regular contact with hospitals, adult and children's social care to ensure that technology strategies and projects remain aligned to deliver maximum benefits
- Production/coordination of bids for additional funding e.g. NHS England Technology Fund
- City-wide Programme Management Group
- Coordination of a portfolio of improvement projects
- Links to Integration Pioneer work and Smart Cities initiative

THE DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Currently using contract resources

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Leeds as a city has gained substantially from having a visibly 'joined up' and integrated Informatics agenda. This has enabled organisations to gain from national funding, gain from national support etc.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£85,000

Project, Programme Management, Project Support and Administrative resources.

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

- Enabler for city-wide working and the benefits that continue to arise from a high national profile in this field.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of*

the proposal to your overall objectives? - *Can you set up a counterfactual or control?* - *Will data be generated automatically or does it require a new survey / data collection approach?*
Transformation Board Transformation Programmes/Projects The Leeds Informatics Board Leeds Care Record Project Board
KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME - *E.g. expertise, staff, demographics, history of partnership working.* - *Do these also exist within the local area?* - *If not – have actions been put in place to resolve this?* - *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?* - *An outline of a stepped approach to implementation which draws on* *I) learning from either local evaluation or other areas where this has been implemented, and* *ii) engagement with partners about the deliverability of the proposal*
All health and social care organisations working in an open and transparent way, sharing visibility of investments, strategies etc.
KEY RISKS - *To the success of the proposal* - *To other parts of the system as a whole (i.e. potentially unintended consequences)*
Availability of quality temporary resources
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
Regular contact with all health and social care organisations Quarterly Informatics Boards Quarterly Programme Management Group meeting Bid for NHS E Tech Fund 2 resources

SCHEME NAME :- 19	
SCHEME NO	Care Act (2014)
RESPONSIBLE GROUP	**Care Act Programme Board**
ACCOUNTABLE LEAD OFFICER	**Sukhdev Dosanjh**
BUSINESS CASE AUTHOR/S	**Sukhdev Dosanjh**
VERSION & DATE	**V2, 11/9/14**

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

1.Care Act will make a positive contribution to the priorities set out in the Joint Health and Wellbeing Strategy. The definition of wellbeing set out in the Act together with its practical impact will greatly assist in the delivery of the key priorities. The themes of empowering individuals through personalised care and developing care services that best fit around their lives. This in turn will help to prevent, reduce or delay the need for statutory care services. The Government expects people dealing with adult social care to be able to articulate clear outcomes from their experience through "I" statements:

- "I am supported to maintain my independence for as long as possible";
- "I understand how care and support works, and what my entitlements and responsibilities are";
- "I am happy with the quality of my care and support";
- "I know that the person giving me care and support will treat me with dignity and respect";
- "I am in control of my care and support and I have greater certainty and peace of mind knowing about how much I will have to pay for my care and support needs".

The main provisions in the Care Act set out above will make a positive contribution to the achievement of the priorities set out in the Joint Health and Wellbeing Strategy. Of particular relevance are the priorities relating to: the number of people supported to live in their own home; more people recover from ill health and ensure people cope better with long term conditions; ensure that people have voice and influence in decision making and increase the number of people who have more choice and control over their health and social care services.

2. The delivery of the Better Lives Programme with its core aim of helping local people with care and support enjoy better lives is one of the Best Council Plan 2013-17 objectives. The Better Lives focus is on giving choice and helping people stay living in their own home, joining up health and social care services and creating the right kind of health and social care support. The Better Lives Programme continues to drive whole systems change within the Leeds health and social care economy and is aligned with the Care Act reforms. It is clear that the reforms will require the Council and its local health and care partners within the City to increase the scale and pace of its transformation programme notwithstanding funding pressures.

The Care Act implementation programme will address the following City priorities with a particular impact in respect of health and wellbeing, business, and communities. The reforms seek to:

- Give people choice and control over health and social care services through personalisation provisions;
- Support the sustainable growth of the Leeds' s economy in terms of stimulating innovation in the care sector and
- Stimulate community empowerment and cohesion through building on the Neighbourhood Networks and encourage the development of prevention schemes.

OVERVIEW OF THE SCHEME

Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

The Care Act (2014) sets out a fundamental review of the law as it relates to care support and planning. The provisions within the Act contain new legal duties, powers and responsibilities as they relate to:

1.The promotion of well-being duty

Adult social care is now to be organised around the well-being of the individual. In effect, 'well-being' is the single unifying purpose around which all adult social care services are to be arranged.

2.The prevention duty

This duty seeks aims to address a key finding in the White Paper in that too often the adult social care system only reacts to a crisis. The Council will have a duty to prevent, reduce or delay the need for on-going care and support. There should no longer be an assumption that all care pathways lead inevitably to institutionalised acute care.

3.Assessments & Eligibility

A national eligibility criteria will be set where a minimum threshold will determine the care needs that will make an individual eligible for the Council's support. Assessments will be revised and expanded, which will mean that there will be a requirement to re-assess people who move into Leeds from another area (principle of portability); assess a large number of self-funders (people who have means to fund their own care); and have a duty to carry out more carers' assessments under the new Carers' eligibility criteria.

4.Prisoners

The Act establishes that the local authority in which a prison, "approved premises" or bail accommodation based will be responsible for assessing and meeting the care and support needs of the offenders residing there if they meet the eligibility criteria.

5.Carers

The Act places Carers on an equal footing with the people they care for. Carers' entitlements and rights are to be enhanced in law with a duty to provide services are to be strengthened following a determination of eligibility under a new Carer's eligibility criteria;

6.Charging and the lifetime cap on care costs

A lifetime cap on care costs will be put in place for people receiving the State Pension which it is proposed is set at £72,000 after which the Council will meet the costs of care. The cap will consist of care costs only and will not include accommodation costs. There will be a duty on the part of the Council to provide a care account which records care costs and track progression towards the care cap.

The "asset threshold" (this is an individual's collective worth e.g. house, savings, benefits and pension) for those who in residential care, beyond which no means-tested help is given, will increase from £23,250 to £118,000. In effect, a more generous means test.

7.Duty to Promote Integration

The integration agenda maintains a strong focus in the Act with the introduction of a duty on the Council to carry out its care and support responsibilities with the aim of integrating services with local

NHS partners.

8.Self-funders

The Act introduces a duty on the part of the Council to meet the needs of self-funders (those people who have means to fund their own care) if they request assistance. The duty to provide advice and information set out below extends to people who have means and are planning how best to meet their future needs care.

9.Advice and Information

The Council has now a duty to advise and inform people so that they can better plan for their future care needs, gain a greater understanding of the adult social care system and improve their access to services.

10Choice and Control

Personal budgets will be enshrined in law for the first time and create a duty on the part of the councils to include them in a person' s care and support plan.

11.Shaping Care Markets

The Act places new duties on local authorities to facilitate and shape their care market for adult care and support as a whole. Councils must meet the needs of all people in their area who need care and support, whether arranged or funded by the state or by the individual themselves.

12Adults Safeguarding

Safeguarding arrangements will be strengthened by placing adults safeguarding boards on a statutory footing and creating a legal duty on the part of the Council to investigate suspected abuse when an adult is deemed to be at "risk of harm".

13Deferred Payments

The act extends deferred payment agreements which allow people to meet their own costs without having to sell their homes in their lifetime regardless of eligibility.

Leeds has initiated a programme of work for implementing the Care Act (2014). The Programme consists of several workstreams which focus on delivering the different aspects of the Act and is overseen by a multi-agency Care Act Programme Board (CAPB) chaired by the Director of Adult Social Services. The programme consists of work with a broad range of stakeholders to: understand and model the impact of the Act; determine the Leeds response to the act taking into account the draft guidance and technical regulations and develop options for how the new duties are best met in Leeds. The workstreams reflect the key priority areas as: 1. Carers; 2. Assessment and Eligibility; 3. IM&T as an enabler; 4. Information and advice, 5. Advocacy 6. IM&T 7.Finance and Metrics 8. Consultation, Engagement and Communication 9. People (OD &HR) 10. Strategic Commissioning 11. Legal Workstream 12. Gateway to Services workstream.

(Care Act (2014) Governance Arrangements, Care Act (2014) Governance Map, Care Act (2014) Project Plan are attached.)

THE DELIVERY CHAIN

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

The implications of Care Act (2014) on our health and social care partners have been considered in a number of joint forums such as the Leeds Health and Wellbeing Board, The Integrated Commissioning Executive and the Transformation Board.
All of our schemes to date 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. Any Service developments which arise from the Care Act (2014) in Leeds will follow this tried and tested pathway.

THE EVIDENCE BASE

Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this proposal?*
- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

The Care Act (2014) is a statutory requirement set by the Government. The Care Act (2014) programme of work is currently in its options/appraisal stage. This stage consists of detailed business analysis, business process review and forecasting. This will help to inform demand and capacity planning, particularly as they relate to carers, assessment and eligibility and self-funders (people with means to fund their own care).

It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for October/November. Following this phase of the programme and a consideration of the options presented, the Leeds health and social care community will make key decisions on how best the new duties will be met. The key objective being to create a sustainable quality health and social care system which effectively discharges the new legal duties and responsibilities set out in the Act.

Key metrics are currently being developed and reviewed using national, regional and local tools. This will help to ensure that key decisions made in strategic are well informed.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

The Funding required from the BCF is £2.6m -£1.9m (Revenue) and £0.7m (Capital).

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

The Consultation, Engagement and Communication Strategy for the Care Act (2014) is attached as an appendix. The strategy sets out the national timeline and milestones; the proposed consultations; communication strands; risk management issues and benefits. It has been developed based on the principles set out in the Council's Engagement Toolkit. The purpose of the strategy is to:

- engage key stakeholders (including service users and carers) to raise awareness of the provisions within the Care Act 2014 and how they affect health and adult social care services;
- make the best use of existing community networks, engagement forums and boards highlighted above to ensure that the direct experience of service users and carers as "experts by experience" help to shape and improve services;
- ensure that the implementation of the Care Act (2014) locally and what it means for the people in Leeds is consistent with the milestones and public awareness programme set nationally and regionally; and
- provide an assurance that the Council fulfils it legal obligations set out in the Local Government and Public Involvement in Health Act (2007) and the Equality Act (2010).

(The Phased Consultation, Engagement and Communication Plan for the Care Act (2014) is attached.)

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*
- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

The Care Act (2014) is a statutory requirement set by the Government. The Care Act (2014) programme of work is currently in its options/appraisal stage. This stage consists of detailed business analysis, business

process review and forecasting. This will help to inform demand and capacity planning, particularly as they relate to carers, assessment and eligibility and self-funders (people with means to fund their own care).

It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for October/November. Following this phase of the programme and a consideration of the options presented, the Leeds health and social care community will make key decisions on how best the new duties will be met. The key objective being to create a sustainable quality health and social care system which effectively discharges the new legal duties and responsibilities set out in the Act.

Key metrics are currently being developed and reviewed using national, regional and local tools. This will help to ensure that key decisions made in strategic are well informed.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

The Care Act (2014) is a statutory requirement set by the Government. The Care Act (2014) programme of work is currently in its options/appraisal stage. This stage consists of detailed business analysis, business process review and forecasting. This will help to inform demand and capacity planning, particularly as they relate to carers, assessment and eligibility and self-funders (people with means to fund their own care)..

It is currently planned that this impact analysis and options appraisal phase of the programme will be completed for October/November. Following this phase of the programme and a consideration of the options presented, the Leeds health and social care community will make key decisions on how best the new duties will be met. The key objective being to create a sustainable quality health and social care system which effectively discharges the new legal duties and responsibilities set out in the Act.

Key metrics are currently being developed and reviewed using national, regional and local tools. This will help to ensure that key decisions made in strategic are well informed.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

(Please see the Care Act (2014) risk register) example extract below:

Version						Assessment prior to mitigating actions					Assessment of risk if mitigating actions are undertaken				
Ref	Project	Work Stream	Type of Risk	Risk Response	Description of Risk	Probability	Impact	Risk Rating	Proximity	Mitigating Actions	Probability	Impact	Risk Rating	Proximity	Risk Status (open / closed)
CC1 - R14	Care Act	Care Act	Statutory Duties/Regulatory	Treat/Adapt	There is a risk the implamentation of statutory duties are not implemented legally.	3	5	15	Project Stage - 4 Delivery	A legal workstream has been established. Adult Social Care's corporate lawyer is part of this group to advise on the legality of options.	2	2	4	Project Stage - 4 Delivery	Open
CC1 - R15	Care Act	Care Act	Statutory Duties/Regulatory	Treat/Adapt	There is a risk that other directorates are not being consulted with in relation to their joint responsibilities for elements of the Care Act (i.e. Housing and Children and Young Persons Social Care.	3	3	9	Project Stage-1 Project Assessment to 6 Post Project Review	Sukhdev Dosanjh to engage with other directorates to establish a suitable officer to be responsible for the Care Bill.	2	2	4	Project Stage-1 Project Assessment to 6 Post Project Review	Open
CC1 - R10	Care Act	Care Act	Statutory Duties/Regulatory/ Legal	Treat/Adapt	The timescales given from the issue of the supporting guidance to implementation will be too short to undertake interpretation and delivery.	3	5	15	Project Stage - 4 Delivery	Undertake forward planning and identify the resources required to implement change. Consult with the National Projects to get as much advice and lead time as possible.	3	4	12	Project Stage - 4 Delivery	Open
CC1 - R5	Care Act	Care Act	Technical / ICT	Treat/Adapt	The new requirements of the Care Act could not be taken into consideration for the initial development of CIS given that these were not known at the time the CIS specification was developed. This may also be the case for other IT developments too e.g. e-brokerage/monitoring systems. There is a risk that the CIS workflow will not be consistent with process changes required to be compliant with the Care Act.	5	4	20	Project Stage - 4 Delivery	New requirements will need to be identified asap to anable the possibility of these being addressed as Day 2 CIS development.	2	4	8	Project Stage - 4 Delivery	New Issue
CC1 - R6	Care Act	Care Act	Technical / ICT	Treat/Adapt	There is a risk that the models coming out of the Care Act for Leeds may be different from that of Calderdale and that Calderdale's implamentation of changes will not be compatible with Leeds processes.	4	4	16	Project Stage - 4 Delivery	Identify differences between Leeds models of service and Calderdale. Any required development costs need to be estimated as part of options appraisals and funding identified when options are agreed. A Calderdale Joint Strategic Board has been established to manage	3	4	12	Project Stage - 4 Delivery	Open
	Care Act			Treat/Adapt	Risk that all the clauses for the Care Act are not reviewed.	3	4	12	Project Stage- 1 Project Assessment to	SME leads have been identified to review the clauses by mid-September '14.	2	3	6		

PROPOSAL IMPLEMENTATION PLAN

- *Start date*
- *End date*
- *List of key deliverables and the dates associated.*
- *Outline roles and responsibilities for delivery and implementation of the proposal.*

(See Care Act (2014) Project Plan) example extract below:

ID	Task Name	Start	
1	**Delivering the Caret Act 2014 High level Programme Plan (v1.10)**	**Mon 07/10/13**	**Fri**
2	**National/Regional Legislation / Guidance**	**Fri 14/03/14**	**Fri**
3	Children an Families Bill Royal Ascent	Fri 14/03/14	Fri
4	Major: Care Bill Royal Ascent	Wed 14/05/14	Wed
5	Major: Consultation on secondary guidance and legislation published	Fri 06/06/14	Fri
6	Major: Response to consultation of secondary guidance legislation closes.	Fri 15/08/14	Fri
7	Major: Secondary guidance and regulations published	Wed 01/10/14	Wed
8	Major: Care Bill provisions in force (Excluding Cap)	Wed 01/04/15	Wed
9	Major: Care Bill Cap provisions in force	Fri 01/04/16	Fri
10	Major: National Stocktake 1	Fri 16/05/14	Fri
11	Major: National Stocktake 2	Fri 17/10/14	Fri
12	Major: National Stocktake 3	Fri 16/01/15	Fri
13	**Programme Management**	**Mon 07/10/13**	**Mon**
14	**Programme Governance (collapse down and not on graphical plan)**	**Thu 13/03/14**	**Thu**
20	**Initial Care Bill Gap analysis (completed)**	**Mon 07/10/13**	**Thu**
33	**Equality Impact Assessment**	**Wed 22/01/14**	**Mon**
34	Complete Impact screening tool	Wed 22/01/14	Mon
35	Task: Equality Impact Assessment	Tue 11/11/14	Mon
36	Major: Equality Impact Assessment complete	Mon 16/03/15	Mon
37	**General/Ad-Hoc tasks**	**Fri 06/06/14**	**Fri**
38	Task: Review draft secondary guidance and legislation	Fri 06/06/14	Thu
39	Major: Consultation on secondary guidance and legislation ends	Thu 14/08/14	Thu
40	Task: Review secondary guidance and legislation	Wed 01/10/14	Tue
41	Major: Review of secondary guidance and legislation complete	Fri 31/10/14	Fri
42	Major: Sign off of operational models post review of guidance	Fri 31/10/14	Fri
43	**Risk Issues and Management**	**Mon 14/10/13**	**Fri**
46	**Delivery**	**Mon 21/10/13**	**Fri**
47	**Workshops**	**Fri 16/05/14**	**Fri**
52	**IM&T Workstream**	**Mon 02/06/14**	**Fri**
53	Major: Establish IM&T working group	Mon 02/06/14	Mon
54	Major: Key Decision - Online assessments	Mon 22/09/14	Mon
55	Major: Completion of IM&T project workpackages for delivery of IM&T project requirements	Fri 26/09/14	Fri
56	Task: Collect Business Requirements for new/revised service models	Mon 29/09/14	Fri
57	Task: IM&T System Design	Mon 22/12/14	Fri
58	Task: Implementation of IM&T systems	Mon 16/03/15	Fri
59	Major: IM&T project work completed	Fri 05/06/15	Fri
60	**CIS**	**Mon 10/11/14**	**Mon**
61	Major: Identify all CIS reconfiguration.	Mon 10/11/14	Mon
62	Task: Undertake CIS reconfiguration	Tue 11/11/14	Mon
63	**Financial and Metrics Analysis Workstream**	**Wed 23/10/13**	**Mon**
64	Major: Establish finance and metrics working group	Fri 01/11/13	Fri
65	Obtain Surrey Model	Wed 23/10/13	Fri
66	Assessment of the Surrey Model	Fri 15/11/13	Thu
67	Completion of initial financial impact	Wed 20/11/13	Tue
68	Major: Baseline finance and metrics signed of by Care Bill Programme Board	Thu 08/05/14	Thu
69	Major: Phase 1 cost of assessments analysis completed	Fri 27/06/14	Fri
70	Major: Phase 2 cost of assessments completed	Mon 14/07/14	Fri
71	Major: Identify the resource to work with private sector to identify self funders	Mon 30/06/14	Mon

SCHEME NAME :- Workforce	
SCHEME NO	**21**
RESPONSIBLE GROUP	**Workforce Group**
ACCOUNTABLE LEAD OFFICER	**Phil Corrigan**
BUSINESS CASE AUTHOR/S	
VERSION & DATE	

STRATEGIC OBJECTIVE OF THE SCHEME :
Vision of the future that the scheme contributes to. Refer to CCG 2 & 5 years plan, LCC and ASC council plans.

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.

OVERVIEW OF THE SCHEME
Please provide a brief description of what you are proposing to do including:

- *What is the business model of the scheme being proposed?*
- *Which service user/ patient group is being targeted?*
- *What are the projected volumes of the service users?*
- *Who will deliver it?*
- *Where and when will it be delivered?*
- *Which organisations are commissioning which services from which providers?*

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 DELIVERY CHAIN
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

- *which organisations are commissioning which services from which providers*
- *Roles and responsibilities for the delivery*

Workforce development is an enabling group of Leeds' transformation programme.

THE EVIDENCE BASE
Please reference the evidence base which you have drawn on,

- *To support the selection and design of this scheme*
- *To drive assumption about impact and outcomes.*
- *What research and evidence did you consult as part of your decision to implement this*

proposal?

- *Have you done any local evaluation to support/ inform this?*
- *What are the key metrics to support the decisions being made?*
- *What are the key metrics to support the financial benefits being claimed?*
- *[Articulate where the evidence base may be relatively weak in support of the proposal OR, if you have not been able to articulate an evidence base in support of each individual scheme, you must include an articulation of what evidence you have consulted to plan your approach to integrated care overall]*

Workforce are key to the transformation work being undertaken across Leeds. This scheme is focused at looking at a holistic view and a planned and coordinated view to workforce changes.

INVESTMENT REQUIRED

- *Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.*

£80k

IMPACT OF THE SCHEME

Please enter details of the outcomes anticipated in Part 2, Tab4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below,

- *Identify the key stakeholders and the impact of the proposal on them?*
- *Reduce activity (whole system/specific)*
- *Reduce cost (whole system/specific)*
- *Improve patient experience.*
- *Impact BCF metrics (BCF national conditions / performance targets)*
- *Other locally important measures or metrics.*
- *What Research and evidence have you consulted to generate a set of assumptions about future outcomes?*

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.

FEEDBACK LOOP

What is the approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- *What is your approach to measure the impact of this proposal?*
- *What measures and metrics will you use? And how will you demonstrate the contribution of the proposal to your overall objectives?*

- *Can you set up a counterfactual or control?*
- *Will data be generated automatically or does it require a new survey / data collection approach?*

In Leeds we will continue to monitor the four core BCF metrics along with a range of other city-wide indicators on a routine basis. This overview for the city against these indicators will be held by the Health and Wellbeing Board, with routine operational monitoring undertaken by The Leeds Transformation Board (which contains representation from all health and social care organisations in the city). The Transformation Board will also oversee other schemes and initiatives that are on-going in the city that will impact on the four key metrics.

In order to model and understand the impact of individual schemes and initiatives the city has chosen to adopt an "Outcomes Based Accountability" (OBA) approach. This approach acknowledges that it is not possible to draw a direct causal effect from an individual scheme on an indicator that is affected by so many different factors (e.g. non-elective admissions). Instead, using OBA means that each individual scheme will have a series of Performance Measures associated with them. These are things that can be operationally managed and impacted on by scheme owners and will provide an indicator as to how a scheme is operating. For example, it might be the number of people trained to do a certain thing that is crucial to avoiding an admission that is monitored. Performance measures will mainly be things that are already managed and measured, but dependent on the specific scheme there may be a need to develop new ways of monitoring them.

Based on these performance measures, it will be the judgement of the Transformation Board to assess which schemes are operating well and should continue to be supported, and which need either re-shaping or stopping completely.

KEY SUCCESS FACTORS FOR IMPLEMENTATION OF THIS SCHEME

- *E.g. expertise, staff, demographics, history of partnership working.*
- *Do these also exist within the local area?*
- *If not – have actions been put in place to resolve this?*
- *OR, what impact will the absence of those supporting factors have on the outcomes that can be achieved?*
- *An outline of a stepped approach to implementation which draws on*
  I) learning from either local evaluation or other areas where this has been implemented, and
  ii) engagement with partners about the deliverability of the proposal

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.

KEY RISKS

- *To the success of the proposal*
- *To other parts of the system as a whole (i.e. potentially unintended consequences)*

These will be managed through the Workforce Transformation Group
PROPOSAL IMPLEMENTATION PLAN - *Start date* - *End date* - *List of key deliverables and the dates associated.* - *Outline roles and responsibilities for delivery and implementation of the proposal.*
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.