Appendix 2

Benefits and outcomes of schemes funded from iBCF non-recurrent monies

Schemes have been categorised to show where funding has been mainstreamed to enable the schemes to continue or where they were only for a fixed term and came to an end on or before 31st March 2021. In some cases, system wide discussions are continuing or are required to determine continuity and sources of funding.

Key
Scheme mainstreamed
Fixed Term scheme now ended
Funding discussions continuing/required

SB3	SkILs Reablement Service
Purpose	To increase system flow of patients by placing Case Officers in LTHT and having dedicated Social Work Assistants to support timely exits from reablement where an ongoing service is required.
Expected Benefits	a) An increase in the number of appropriate referrals to SkILs from LTHT – average monthly referrals = 181 b) A reduction in the number of people in transition from reablement – average monthly number of people in transition = 80 c) A reduction in the length of time people are supported in transition by reablement from 4.5 weeks
Outcomes	a) Sept 19 =205, Oct 19 = 205, Nov 19= 241 b) Aug 19 = 45, Sept 19 = 93, Oct 19 = 85, Nov 19= 64 c) 3.7 weeks • SkILs Case Officers were on hospital wards from 12 to 3pm following up customers that the Discharge Teams identified. They talked to patients about the service and how it would support them at home. • Improved service productivity and customer satisfaction

SB7	SWIFt (supporting wellbeing and independence in Frailty) Scheme SB85 continued this work
Purpose	The aim of this service is to work with older people who are living with frailty, socially isolated and with complex issues to improve their quality of life and support them to live independently by: • Helping them to identify ways to build self-confidence and resilience • Providing practical support to help them achieve their aspirations • Ensuring they are accessing the support services they require The service offers targeted, person centred 'wrap around' support.
Expected Benefits	a) Improve the health and wellbeing of older people reducing their risk factors for increasing frailty b) Reduce social isolation and improve support networks for older people to increase resilience

	c) Support a greater number of older people to live independently and safely in their own homes increasing time spent at home and reducing hospital and care home admissions d) Provide person centred support for older people working across the health and social care system complementing existing services e) Improve the wider determinants of health, including economic disadvantage and discrimination
Outcomes	a) 62% experienced an improvement in the health and wellbeing b) 49% experienced an improvement in their social isolation c) 1027 home visits were completed between 1st April 2019 and 31st March 2020 d) 372 action plans were completed between 1st April 2019 and 31st June 2020 e) 12 case studies were submitted for delivery between 1st April 2020 and 31st June 2020

SB8	Customer Access
Purpose	To fully adopt strength based social care, the following changes will need to be put in place this year:- • A new strength based conversation at the first point of contact • Calling customers back as standard after receiving referrals from third party • Increase the use of Leeds care record for data gathering on all email referrals • A new process that includes an increase in mental health referrals at front end and the rolling out of a system that allows Customer Service Officers (CSO) to book into talking points across the city.
Expected Benefits	a) Increase signposting from 53% b) Increase number of customers booked into a talking point at first point of contact from 2 sessions per week in Armley to 2 sessions per week across 13 neighbourhoods
Outcome	a) Signposting = 58% over reporting period b) 45 per month Performance figures indicate that the contact centre is logging less non referral contacts for known customers. This is an indication that failure demand is decreasing.

SB12	Local Area Coordination & Asset Based Community Development (ABCD)
Purpose	The purpose of this scheme is to support communities using local area coordination and ABCD principles to respond to the needs of people who have or may be in need of social care support.
Expected Benefits	a) Improved quality of life for people with low to moderate learning disabilities b) The ABCD pathfinders will help to improve wellbeing and community resilience in the neighbourhoods in which they operate; supporting the rollout of strengths based social work. c) The interdependencies of communities are recognised and strengthened. All members of the community feel welcome including people with learning disabilities.
Outcome	a) Two ABCD pathfinders with a learning disability lens established one hosted by HFT and one hosted by Better Action for Families. They are supporting a

community connector to set up a support group for parents with children with learning disabilities. Working with Aspire CIC to implement asset based approaches in their services. HFT are working with two people with learning disabilities who would like to become community connectors and would like to hold their own social groups and have created a pictorial questionnaire to give out to local residents who attend the courtyard café that provides creative activities for people with learning disabilities. Person with learning disabilities ran a coffee morning for six weeks at New Wortley Community Centre. BAFF held second skills event in local library in Beeston new people have attended this, shared skills and interests. Garforth now have 3 new community connectors with Learning Disabilities. Rothwell Community Connector held the first games group at a local café.

b) We now have 12 Pathfinder sites (13 ABCD Community Connectors as 1 Pathfinder site has two grants) established across Leeds and 13 Community Builders. 1 pathfinder site has Carers Lens focus and 1 Pathfinder site with a Schools and literacy lens. 10 of the Pathfinder sites are funded until 2020 and 2 until 2021. Of these 12 Pathfinders sites we now have 113 community connectors, with 91 activities held by the Community Builders and/or Community Connectors with 688 number of attendees total. The Pathfinder sites have made 336 connections with other organisations to raise awareness about ABCD in their area. Touchstone has delivered 6 ABCD Intro and Bespoke ABCD sessions to over 87 people from organisation such as NHS England, Health watch and Kirklees Council. The last ABCD intro session was online due to Covid19 and we saw a range of local authorities and regional council's such as Stoke Council, Calderdale, Kirklees and regional third sector organisations who are keen to have further conversation and sharing of good practice the ABCD model in Leeds. The team have spoken with 236 individual organisations, attended meeting/briefings/events or been asked to present to influence and share Asset based principles. We are working with a care home to see how they develop strength based practice for staff and sharing of gifts of their residents, this has been paused for now. ABCD Conference was due to be held in March and invited all SLT Directorates across the council with workshops from other directorates in the council that have adapted an asset based approach: Housing, Communities and Environment and Sports and Culture. We delivered ABCD Intro training at the recent TARA conference for housing. Housing Leeds are now creating a 'small sparks' fund for local residents through the Housing Association Panels, we are supporting them in how the process and mechanism will look and how we look at what meaningful measures and positive impact will be captured longer term. Work between the 'Linking Leeds' social prescribing service and how it works jointly with the Community Builders has started.

c) SRG figures 334 (228 new) people currently members of a self-reliant groups in pathfinder areas. Residents in Lincoln Green have created a gardening group called 'collecting together' they're plan is to invite more local residents who are passionate and can share their gardening skills to collectively create greener spaces for all the community to enjoy. Lincoln Green Pathfinder held a participatory budget event called "U Choose Lincoln Green", inviting community residents to come and pitch ideas for their SRG idea to a panel of community members who oversaw the spending of the small parks budget. SRG'S established were: A weekly women's swimming group, A community litter pick and planting session, with a BBQ and family activities, A football tournament, for young people across Lincoln Green and longer term football activities/club ran by residents, A bi-weekly activities programme focused on Women's health and empowerment, A Mother and Daughter social club,

	based on intergenerational learning. The East Street Arts programme has finished and a number of ladies who have attended the group have now decided they would like to run their own craft group to be able to sell some of the work they have created and are in the process of setting up their own self -reliant group. <u>Response to the COVID-19 Pandemic</u> Three of the ABCD pathfinders have become Community Care Volunteer response hubs and two have mobilised their organization in response to the need of residents who they support. For some residents there has been welfare check ups, supporting residents' wellbeing and health. More recently we have seen a shift in Community Builders getting back to focusing on what's strong for people and their associated life, rather than what's wrong and their needs. What has been coming out of a lot of conversation with the community builders is that sense of coming together, many individuals coming forward to offer time, support, money and ideas to help and be part of their community. The Community Builders have shared many examples such as: weekly zoom coffee mornings, street support groups and street bingo. Lockdown projects such as playing music for the community through social media, raising money for NHS Charities Together. Community Builders have been utilising social media platform to share cooking recipes, knitting patterns and adapted easy ready exercise plans. A community connector and her daughter are making weekly Sunday baking videos on YouTube, and the recipes are then put into the play boxes for families to do together, to date there have been 500 mini boxes have been delivered to families in the Seacroft area.

SB13	Dementia (information and skills)
Purpose	To commission improvements to online information about living with dementia in Leeds and to develop further dementia training for social care providers
Expected Benefits	a) More people and carers would be connected to local support to live with the condition, and meet other people who share their circumstances. People with memory problems / family members who search online would find some reassurance that they're not alone with problems and there is help 'out there'. b) More people with dementia would be cared for by staff with appropriate skills and knowledge.
Outcome	a) Website development on hold pending other local developments re. online information (risk of duplication and not joining up effectively) b) In Q3 2019-20 38 people completed the Council's training offer at Skills for Care Tier 2 and 11 managers/senior staff completed the Council's training at Tier 3

SB14	Falls Prevention (links with SB61 Falls Pathway Enhancement)
Purpose	The Falls Prevention programme is targeted at older people living with frailty who are at higher risk of or who have experienced a fall (predominantly those over the age of 65). The work underpins and enhances the Falls Pathway and supports the urgent care and self-management pathways by seeking to reduce the rate of unplanned admissions.
Expected Benefits	a) Clients self-reported an improvement in confidence and reduction in fear of falling

	b) reduction in care home admissions c) reduction in admissions to hospital admitted due to falls related injuries d) Reduction in admissions to care homes; increased independence/less need for care packages.
Outcome	a) Q1 - 85% of participants had an increase in Timed Up and Go scores. Q2 - 72 % of participants had improved their TUG score by week 20 and 65% have improved FES and 65% improved for ConBal. Total number of participants assessed 54. Q3 - 14 participants from the two completed courses finished their assessments. 64% improved their TUG. 79% Improved ConBal. 93% improved FES Q4 - 56 participants from seven completed courses and assessments. 75% improved their TUG. 71% improved ConBal. 70% improved FES b) c) d) Unable to extrapolate from data – being reviewed as part of longitudinal evaluation and cohort comparison.

SB15	Time for Carers
Purpose	To continue to fund the Time for Carers scheme which is a well-established, successful and popular scheme administered by Carers Leeds and which provides unpaid carers with a small grant of up to £250 in order that they can take a break from caring.
Expected Benefits	Increased quality of life for carers Early identification of carers
Outcome	A total of 190 grants have been awarded in 2019/2020 Estimated 110 carers who received a grant also received additional support from Carers Leeds

SB17	Working Carers
Purpose	To provide a funding contribution in order to expand existing and on-going work at Carers Leeds 'Working Carers Project' aimed at working with employers to improve support for carers who are in employment. The funding will also support the project to encourage SME's in Leeds to take advantage of Employers for Carers membership.
Expected Benefits	a) Reducing the disadvantages that carers who give up work to care experience (e.g. loss of income, impact on health and wellbeing, social isolation) b) Reduction in carers giving up work to care through an established network of Leeds employers. c) SME organisations benefiting from Employers for Carers membership
Outcome	a) A range of support offers for employers and working carers has been developed and are in use. b) Network of Leeds Employers is established c) Employers for Carers Membership is confirmed for 2019/2020

SB21	Prevent Malnutrition Programme
Purpose	To fund a programme of work known as the 'Leeds Malnutrition Prevention Programme' that will include:- a) a series of malnutrition campaigns b) the dissemination of resources c) the increased effectiveness and capacity of the older people nutrition training (Improving Nutritional Care & Nutritional Champions) across the health and social care workforce and allied health professionals

	d) the reintroduction of the 2012 'Winter Pressure Project' which included a single point of contact for health and social care professionals who identified an older person to be at risk of malnutrition.
Expected Benefits	a) Number of health and social care staff trained b) Increased nutritional knowledge and confidence within health and social care staff c) Number of older people resources distributed d) Number of calls to single point of contact and outcomes/resolved e) Decrease in admissions and home care requirements due to malnutrition
Outcome	a) & b) Training for health and social care staff; Improving Nutritional Care (older people) courses are booked and delivered by Leeds Community Healthcare. Courses are mostly full with a small number of places allocated to the third sector. Courses evaluate well and are embedded in the training offer by OD. LCC OD have agreed to continue to fund courses for H&SC staff to attend following the completion of the Malnutrition Prevention Programme IBCF funding. Courses link to the Leeds Food consensus, provide an opportunity for staff to share best practice, ask questions and collect resources suitable for their settings. c) **Number of Resources Distributed;** The next hot meal campaign provided opportunities to prompt conversations between staff and volunteers and those who are most vulnerable living in their own homes. Resources along with a staff briefing were provided to H&SC staff, neighbourhood teams, neighbourhood network staff and other third sector providers. The campaign signposts people to the malnutrition helpline and the Leeds food consensus webpage which provides signposting, support and the 8 key questions that can support a conversation around malnutrition. Leeds has recently been awarded the **Sustainable Food Cities Bronze Award** - during the presentation, Leeds was acknowledged for having a wide range of excellent work across the food system. Several projects and initiatives were highlighted as being particularly innovative including the **Next Hot Meal** campaign. **d) Number of calls to single point of contact and outcomes/resolved;** 29 calls received in total – all reported as resolved. Recent resolved queries not reported in previous quarters include; GP/professional queries about signposting and promotion to patients/service users; care home staff asking about dementia and weight loss – advice was provided about the food first approach; a family member asking for advice about dementia and support available; a member of the public asking for advice about quitting smoking and weight loss. Leeds Community Healthcare has agreed to continue to keep the helpline running and will work closely with public health to monitor calls and outcomes. This programme ended in Q2 19/20

SB22	Better Conversations
Purpose	To train health and care staff to have 'better conversations' with the citizens of Leeds and move the conversation to a 'working with' approach.
Expected Benefits	a) Health and Care workforce competent in the skills required to have better conversations. b) People in Leeds are supported to achieve what matters to them c) Decrease in use of services d) A unified approach with health and care partners across Leeds e) Alignment with Leeds Plan outcomes

	f) Alignment with Population Health Management approach and strength based social care g) Providing the culture change required for system integration and city first ambition h) Minimising the costs (financial and personal) of preventable illnesses and dependency, inappropriate admissions and prescribed medications. - Significant savings to the wider social system (Health Foundation) estimates this to be £22M for Leeds. i) To achieve the ambitions within the 5 Year Forward View, the Care Act (2014) and NHS Constitution j) Improved staff engagement, resilience, motivation and job satisfaction. k) Improved recruitment and retention. l) A workforce with the skills, abilities, confidence and attitude needed to deliver services to support sustainable m) Increased capability for people to self-manage n) Increased goals set and achieved by people about what matters to them o) A sense of shared responsibility and risk between public sector organisation and the citizens of Leeds- Changing Leeds
Outcome	a) By the end of December, 1454 staff have been through 128 skills days. As of 19/3/2020 – 1,635 have been through 147 skills days. However COVID-19 has had an impact on Q4 numbers – 4 skills days would have run and a potential of 52 attendees is now no longer viable. b) Data collection has commenced on this element. c) Due to COVID-19, we have had to stop running the skills days. The economic analysis will form part of Yr 3 evaluation d) Wide group of stakeholders across health and care providers. Data collection to be completed via HaCES as of evaluation report. e) Ongoing – at the heart of Personalised Care. f) Workshops delivered to 2 of LCP areas and 2 were planned in February and March (both were cancelled due to COVID-19). g) By the end of December 1454 staff have been through 128 skills days. As of 19/3/2020 – 1,635 have been through 147 skills days. However COVID-19 has had an impact on Q4 numbers - 4 skills days would have run and a potential of 52 attendees is now no longer viable. h) Further economic analysis is built into Year 3 of the evaluation i) This programme is central to the personalised care critical foundation of the LTP j) 4 month surveys - Deployment areas – 2 Non-deployment areas - 24 8 month surveys - Deployment areas – 2 Non-deployment areas - 14 12 month surveys - Deployment areas – 1 Non-deployment areas - 25 Case studies = 3 k) Business Support Officer left the project 10th January 2020. Improvements made within existing team and 2 x BC Assistants promoted to full-time Project Officers – COMMS Lead and Project Lead from 9th March. l) Interim evaluation report from HaCES m) PAMS measurements data no longer collected n) PAMS measurements data no longer collected o) Staff and citizen surveys

SB23	Alcohol and drug social care provision

Purpose	To fund front line drug and alcohol services for residential rehabilitation, Turning Lives Around (formerly Leeds Housing Concern) and spot purchase in order to meet the needs of patients requiring specialist drug and alcohol services.
Expected Benefits	a) Funding alcohol residential rehabilitation (at St Anne's Alcohol Service) b) Funding Carr Beck Service, Turning Lives Around (Formerly Leeds Housing Concern) c) Funding Drug and Alcohol spot purchase
Outcome	a) During 2019/20 a total of 72 people commenced rehabilitation and a total of 77 people left the service including some who had commenced their residential placement the previous year. Of those leaving, a total of 53 successfully completed the full 13 week programme representing a successful completion rate of 69%. Covid-19 had a small impact during the second half of March as some service users chose to leave early and new admissions ceased. All clients including those who did not successfully complete the programme had an aftercare plan in place. For the majority this included ongoing support from the Forward Leeds drug and alcohol service with many engaging in other forms of post rehab support including mutual aid, housing and employment support and statutory services as appropriate. b) The service provides support for women who are alcohol dependent and require support in managing and reducing alcohol consumption and dealing with housing, health and other related needs. During 2019/20 a total of eight clients have been supported with two successfully undertaking a planned move on to other accommodation. One moved to a Council tenancy and the other person moved to alternative supported accommodation. One third move on meets the expected performance target for the 12 month period. Besides help to reduce alcohol consumption, support has been provided as appropriate for other issues such as physical health problems, risk of domestic violence, drug use, self-neglect. Carr Beck continued to support service users remaining with the service throughout the emerging Covid-19 pandemic in Quarter 4. c) This programme provides out of area rehabilitation for drug misuse (there is no residential drug rehabilitation provision in Leeds). It also supports a very small number of alcohol clients, for whom undertaking residential alcohol rehabilitation in Leeds is unsuitable, to access this out of area. During 2019/20, a total of 44 people commenced an out of area placement. Of the 38 who completed or left their placement during the year, 15 did so successfully, 19 unsuccessfully and the outcome of 4 is yet to be confirmed. Covid-19 had a small impact towards the end of the year as some providers closed due to the pandemic which affected admissions and unplanned exits during the second half of March.

SB25	Peer Support Networks
Purpose	To develop a sustainable network of peer support groups across Leeds for people living with Long-term conditions
Expected Benefits	a) Explore whether Breathe Easy Support Groups in Leeds are sustainable b) Do peer Support leaders feel appropriately skilled/confident to sustain groups. Understand why/why not c) Explore if consistent systems in place for holding up to date availability of peer support groups

	d) Peer Support Networks exist / are effective / are sustainable (could be formal / informal / digital)
Outcome	a) We continue to have 5 Breathe Easy groups running. There is a variance in sustainability of individual groups. Sustainable groups have leaders who feel confident and appropriately skilled for the role. CCG are completing a literature review on the Breathe Easy groups. Joint working continues with the Digital Inclusion Coordinator to offer digital training and equipment to peer support leaders. We are also actively exploring digital resources and platforms for these groups. b) We are developing a resource pack that will outline key information to support Breathe Easy group leaders in planning and organising their bi-monthly meetings. In addition, Active Leeds is working some exercise trainers to upskill them. Variance in accessible training and support identified. Informal training package now available and shared which has been further developed by the new Leeds Mental Wellbeing Service and being delivered to first cohort of volunteers in April 2020. There are various organisations that offer training and support for leaders, however, most incur a cost which can be a barrier for smaller grass roots groups. We are currently scoping how the Leeds Peer Support Network (an existing group) can be further developed, including how this network could be a source of free training and resources. c) Leeds Directory has a consistent system in place to hold information on Peer Support Groups; this is promoted within the role. The Neighbourhood Networks Schemes have systems in place such as websites, social media platforms and newsletters. d) There is an existing Peer Support Network in Leeds however this network is not being used to its full potential and further discussions needed for example on how to include more peers to ensure sustainably. Joint working continues with the Digital Inclusion Coordinator to offer digital training and equipment to peer support leaders. We are also actively exploring digital resources and platforms for use by the group leaders.

SB26	Lunch Clubs
Purpose	To continue to fund the Lunch Club small grants scheme for 2018/19 targeted at older people, with the aim of decreasing their social isolation; increase their opportunity to access a nutritional meal and decrease their need for care and support.
Expected Benefits	Lunch Club provision prioritised in deprived, isolated & BME groups Non-prioritised lunch clubs receive contribution Service users (older people) in prioritised wards benefit from an affordable hot meal Maintain or Reduce community malnutrition (underweight recording) Reduced social isolation All lunch clubs are registered with Food Safety team Leeds Establish minimum Food Hygiene Rating for Lunch Clubs
Outcome	Lunch clubs delivered across the city engaged a large number of attendees through the variety of delivery models. Lunch clubs provided colleagues with opportunities to engage older, vulnerable people in a variety of activities including adapted table tennis activities, information on E Coli and preventing infections, Get Set Leeds the physical activity social movement and Seriously Resistant – the campaign helping Leeds to keep antibiotics working.

SB28	TCV Green Gyms

Purpose	To fund Green Gyms where participants are guided in practical activities such as gardening and grounds maintenance. TCV will run four weekly sessions spread across Leeds and two health walk groups. There will also be an extensive programme of outreach and pop up sessions to recruit from the target populations.
Expected Benefits	a) Improved Physical health – target =55 Actual = 52 b) Improved mental wellbeing – target = 55 Actual = 67 c) Maintain or progress recovery – target = 55 Actual = 45
Outcome	We exceeded our recruitment target of 420 volunteers recruited over the life of the project. The Green Gym project saw the 428th volunteer sign up in the final quarter and we worked with our 28th group. We continued to work with the six Green Gym gardening groups and two Green Gym walking groups across Leeds plus a group of residents, Seacroft Community on Top. This latter designed and planted up an area by their local community centre and developed a maintenance plan. We engaged someone to carry out a Listening Project style activity who started to record volunteers talking about how GG has impacted their lives. The IPAQ and Outcome Star evaluations we have demonstrate that over half of Green Gym participants attending 5 times or more increased the amount of vigorous and moderate activity they did, and over 70% increased the number of days when they would walk for at least 10 minutes. This is supported by anecdotal evidence from volunteers who have described finding activity and exercise easier and pushing themselves to do more, and joining other groups of interest as they felt more confident and able. Outcome Star, ONS Subjective Wellbeing and SWEMWBS evaluations show that the mental health of the majority of volunteers has improved and they felt more able to manage it. Over 80% are more satisfied with their lives and are less anxious (pre-Covid-19) and more than 70% feel that their lives are more worthwhile and happy, and they feel more relaxed. Over 60% felt more optimistic and useful, and were able to think more clearly, deal with problems well, feel close to other people and make their own mind up about things. Impact has been seen in an increase in people's social networks and satisfaction with their social lives. Importantly. There have been improvements in how people feel about themselves and how they define who they are.

SB30	Neighbourhood Networks
Purpose	Neighbourhood Network schemes are community based, locally led organisations that enable older people to live independently and proactively participate within their own communities by providing services that reduce social isolation, deliver a range of health and wellbeing activities, provide opportunities for volunteering, act as a 'gateway' to advice/information and other services resulting in a better quality of life for individuals.
Expected Benefits	a) More older people supported by NNS – Target = 26,500 b) Increase in the number of Older People prevented from being admitted to hospital – Target = 650 c) Increase in the number of Older People receiving hospital discharge support – Target = 175 d) Increase in the number of activities delivered to support health and well-being – Target =900
Outcome	a) More older people supported by NNS - Actual = 26,881 b) Increase in the number of Older People prevented from being admitted to hospital – Actual = 6211

	c) Increase in the number of Older People receiving hospital discharge support – Actual = 1405 d) Increase in the number of activities delivered to support health and well-being – Actual = 970

SB31	Leeds Community Equipment Service
Purpose	To increase the BCF funding for Leeds Community Equipment Service
Expected Benefits	Supports the service to deliver the community equipment element of the LCETS Service Specification – Target 97% level 1 and 80% level 2 People are supported to remain at home or return home following admission to hospital or community bed Management of risks related number of people waiting for equipment and the value of that equipment
Outcome	Q3 19/20 97.03% level 1 equipment delivered within 48 hours Q3 19/20 98.04% level 2 equipment delivered within 14 days At the end of Q4 18/19 there were 235 people waiting for equipment with a value of £217,799. The longest delay was 9 months.

SB34	Ideas that change lives Investment Fund
Purpose	To 'top up' the current ITCL investment fund as it is currently oversubscribed. The additional funding will be particularly focused on encouraging the development of social enterprises in more deprived communities and the business support that works alongside the fund will also be refocused to support this.
Expected Benefits	a) DAMASQ is a Syrian organisation that supports migrants, refugees, asylum seekers and older people in east Leeds in a range of ways. This funding will be used to run a six month programme of activities particularly for older and disabled people to improve their life skills and increase their resilience in coping in the modern world. The programme will address IT/social media skills, cooking, finance, fitness and hobbies. b) Fall into Place Theatre delivers drama groups and workshops that are tailored to suit a range of abilities and are accessible for people who have dementia, physical disabilities, and mental health needs. Through drama they seek to improve beneficiaries' wellbeing, self-confidence and social skills, to delay degeneration and increase mental and physical health. Consequently this will enable people to remain independent for longer. They will be working with GPs to determine if people attending their groups are reporting less illness and isolation. c) **PingPong4U** were awarded a contribution towards delivering adapted Ping Pong activities that provides fun, exercise and breaks down social isolation for people in LS7, LS8 and LS9.
Outcome	a) DAMASQ delivered the project but not in the way they had planned as some of their face to face activity had to be moved online due to distancing requirements and lockdown. As one of the elements of their programme was to increase the IT/social media skills of the target group, they were already well placed to help meet the demands of the lockdown. Through delivering the project they have learnt that they want to expand their online offer to older and isolated people to enable more people to be connected. b) As with the other projects, Fall into Place Theatre had to adapt their offer due to the restrictions imposed by government. This organisation was a key

	member of one of the Community Hubs that were created by the council in response to the pandemic. They were instrumental in devising and putting together activity packs for families who were isolating due to the virus. The packs were initially distributed locally with food packages but this increased to citywide distribution as other areas heard about them. The packs were very well received by families who were struggling to find meaningful activities for housebound members of the household. c) PP4U has also had to adapt its offer due to the pandemic but has delivered online tutorials for organisations with an interest in adapted sports. They intend to expand their online offer in future and are selling training packs and equipment to organisations across the city.

SB35	Adults & Health Change
Purpose	The funding is being used to improve the standard of client record keeping and also to ensure a more efficient and effective payment and billing system is in place.
Expected Benefits	a) Deliver additional Income from the recovery of Client Contributions due from both new and existing Clients – Target = £30m 19/20 b) Client Details brought up to date c) Prompt payments and reduced queries from providers
Outcome	a) £30.5m (projected) with a FYE of £30.9m in 20/21. Further savings areas already scoped for future years b) Identified over 1000 records that require cleansing. Programme in place to cleanse those records which will not only allow prompt payment of invoices, but also generate further income. c) Backlogs and time taken to complete financial assessments are reducing and part of the additional capacity now in place will ensure that appropriate reporting arrangements to monitor this are put in place towards the second half of 19/20.

SB37	Assisted Living Leeds – Volunteer Drivers
Purpose	To create volunteer driver posts at Assisted Living Leeds to collect small items of equipment, that do not require any technical ability to disassemble or remove, such as Zimmer frames, commodes, pick up sticks cushions etc.
Expected Benefits	Items of equipment will be collected in a more timely manner
Outcome	Q3 average waiting time for collection = 6 days, value of items collected = £1.5m Collections are now booked with customers when they ring to ask for a collection. These are within 7 days unless a customer asked for a date suitable for them. This means that the service has less failed visits. The average waiting time is now down at 6 days. The service will be developing this service to have areas of the week when they will be collecting. This project is not using volunteers. Commissioners when to tender but there was no bids from the voluntary sector so it was agreed that LCES could employ someone to do this project.

SB44	Intensive Positive Behaviour Service
Purpose	This bid is for an Intensive Positive Behaviour Service which will work intensively with young people with behaviours that challenge and learning disabilities at risk of needing external residential placements, reducing the need for residential placements or emergency hospital treatment and admissions in childhood and adult life.
Expected Benefits	At least 35% increase in the proportion of children with Learning Disabilities and challenging behaviour that remain successfully at home. Improved family functioning. Improved outcomes for children and families in cohort
Outcome	Eight families have been supported by the project, four of whom have received intensive support at home. Two of these families are more recently referred and are in their extended assessment phase. Two cases have been discharged. These are all families who fit the project criteria and were severely challenged in their ability to cope with their child's challenging behaviours. The project workers have built up good relationships with wider agencies and this is strengthening multi-agency working around these families, which was historically considered weak. Wider agencies want to work in partnership with IPBS, although time is a constraint. The project has trained (for example) social workers, Specialist Inclusive Learning Centre's (SILCs) and transport staff to improve understanding of the PBS approach, which has been very well received with some agencies wanting more training and consultation. This is part of the project's strategic objective to change expectations and culture to avoid professionals assuming that this cohort of children will need residential care. Benefits to families include obtaining a fuller understanding of need from a thorough assessment; parents learning and using visual/sensory behavioural tools and understanding behavioural triggers; workers providing a listening ear; parents being believed in terms of the severity of the situation at home; getting the right people round the table to share information and agree consistency in next steps/approaches; access to different support packages; and some parents feeling more hopeful. There are examples where this support has reduced challenging behaviours and changed attitudes to the urgency of need for residential care

SB49	Yorkshire Ambulance Service Practitioners Scheme
Purpose	To fund two Emergency Care Practitioners to be based at the Urgent Treatment Centres who will provide both navigation services and support to minor illness and minor injuries through clinic sessions. To also fund 1 part-time ECP supervisor.
Expected Benefits	a) improvement in 4 hour Emergency Care Standard – target = 99% b) Staff satisfaction rates c) improvement in 15 minute time to assessment – target = 40%
Outcome	a) 99.2% in Q4 b) Improvement on pre rotation comments c) 27% in Q4

SB50	Frailty Assessment Unit
Purpose	To fund a multi-agency frailty service initially in St James' to support a strength based approach to the management of frail people presenting or conveyed to the emergency department and promote the ethos of Home First.
Expected Benefits	a) Reduction in the number of non-elective admissions – target = 1200 over 12 months

	b) Bed Days Saved – target = 2400 days over 12 months c) Number of attendances to Frailty Unit – target = 2000 over 12 months
Outcome	a) 972 b) 1944 c) 1498 Qualitative Benefits • Patients received early Geriatrician input in the Frailty Assessment unit, this not only leads to a better patient journey but increased the number of patients seen within the 14 hour target. • Improved patient journey, providing a considerably better experience not only for patients but for their families and carers. Allowing a multi-disciplined approach to care with input given by families and carers at the point of assessment rather than post admission. • Early clerking of patients and senior review before being admitted to medical wards improves patient experience and results in a clear admission plan on admission which may subsequently positively impact on their length of stay.

SB52	Hospital to Home
Purpose	To fund the Leeds Integrated Discharge Service – a multi-disciplinary team to ensure that where possible admissions into hospital are avoided from A&E and the assessment area. In addition the team works across a number of medical wards to support timely discharge of adult medical patients who have presented to the hospital.
Expected Benefits	Reduction in Non-Elective Admissions Reduced bed occupancy Reduced need for home care (ASC and NHS) Reduced DTOC Bed days associated with Choice Improved A&E Performance
Outcome	This period has seen progress made in finalising the Service Specification and interim Contract for Hospital to Home which will transfer to a service directly commissioned by the CCG with effect from 1 April 2020. The Hospital to Home service is now an established as a component part of both the discharge process within LTHT as well as contributing through its alignment with the Frailty unit to reducing the risk of unnecessary admission. It is worth noting that in the four years that the service has been fully operational Hospital to Home has completed a total of 6293 individual activities with the range of support now offered extending to include pre-discharge 'home comfort' assessments, medication delivery and post-discharge practical support for up to 3 days. The impact of the initial outbreak of Coronavirus has had a direct and significant impact on the Hospital to Home service in this period. The early months of 2020, notwithstanding normal and anticipated winter pressures where comparatively routine, with referrals for the core 'transport and settle' service sustained at manageable levels. However, as the volume of infections increased the hospital trust introduced measures to both treat those who had tested positive and to minimise the risk of harm to people requiring treatment for other conditions. As a consequence, towards the end of this reporting period the volume of referrals received by the H2H service was beginning to decline.

	In response, at the request of the CCG we have extended our support to cover all age groups and increased the number of sites across which the service operates to include the Leeds General Infirmary, Chapel Allerton, Wharfedale, Step-down beds in care homes and The Mount, in addition to St James's Hospital. We have also agreed to accept a small number of referrals for medication prompts from the Reablement Teams within Leeds City Council and for post discharge support for patients with mental health needs being discharged from The Mount. The team have also been making proactive wellbeing calls to check how former patients are doing during the current crisis and offer support where needed. The service has now moved to using minibuses to transport people home rather than our staff using their own cars, as this provides for adequate social distancing and enables us to transport more than one person at a time (whilst ensuring 2m between each passenger). Access to PPE has been a challenge, as is the case everywhere, however the hospital trusts have been supportive and access to equipment has improved. As it stands we have adequate supplies, however, demand for our services has been relatively modest in recent weeks, as a result of the hospitals operating at around 60% capacity, with many routine procedures postponed due to the COVID-19 emergency response. Our PPE requirements will continue to be carefully monitored should we see the widely anticipated increase in referrals. To support any future spike in demand for hospital discharge we have also been allocated volunteers recruited by Leeds City Council in collaboration with Voluntary Action Leeds. We have developed a role profile for these volunteers who will provide additional assistance on the minibuses and assist staff to ensure people are safely escorted whilst being transported home.

SB54	Staffing Resilience
Purpose	Contingency funding for 3 agency Social Workers to cover any exceptional surges in LTHT and out of Leeds inpatient facilities during the winter period
Expected Benefits	The contingency funding will ensure that ASC meets the trajectory around DToCs by ensuring timely assessment and access to funding where required
Outcome	There has been a decrease in delayed transfers of care due to the extra social work posts

SB55	Business Support for Discharge Process
Purpose	To fund additional Business Support in HSW to accommodate the centralisation of all hospital discharges within the HSW service. This additional Business Support will enable Social Workers to smoothly discharge Leeds residents from hospital settings. Business Support provides essential capacity to the Social Work role, and also undertakes quality checks on resource allocation requests
Expected Benefits	Sufficient Business Support capacity to enable Social Workers to smoothly discharge Leeds residents from hospital settings. Business Support provides essential capacity to the Social Work role, and also undertakes quality checks on resource allocation requests. Leeds residents spend less time in inpatient beds, and return home with the appropriate level of support.
Outcome	From October there was an increase in the referrals, assessments & support plans which saw Business Support workloads double along with an increased number of SW staff to support. What we achieved was managing to stay on top of the critical tasks. The posts support improving data quality. Utilising weekly and monthly reporting to capture the required data; Business Support Manager in HSW is able to report any

	issues to the SDM/HoS for action by weekly and monthly reporting to capture the required data.

SB58	Respiratory Virtual Ward
Purpose	To fund a Respiratory Virtual Ward to provide intense respiratory support to a defined cohort of patients in their own home.
Expected Benefits	a) Identify people who can be supported to remain at home – target = 25 patients per month b) To reduce numbers of admissions – target = 25 patients per month c) To reduce length of stay d) Increase numbers of people in the community with an enhanced care plan to manage exacerbation – target = 25 per month e) Improve outcomes reported by individuals and by use of standardised assessment tools f) Improve confidence to self-manage and remain at home reported by individuals/families/carers
Outcome	a) Q3 – 41 patients supported on the virtual respiratory ward. b) Q3 – 21 out of 41 referrals were from community setting d) Since 1st September all patients on the VRW have been supported with a self-management care plan. e) 68% of patients demonstrated an improvement on discharge from the VRW in the COPD outcome measure Service mainstreamed

SB61	Falls pathway enhancement (links with SB14 Falls Prevention)
Purpose	The Falls scheme is predominantly focussed on older people living with frailty people, particularly those with multiple long-term conditions living in their own homes or in care homes. However the increase in diabetes is also having an impact on the risk of falls in younger adults. This work will predominantly affect the citywide Falls pathway, with links to long-term conditions and frailty pathways.
Expected Benefits	a) Support achievement of Sign Up to Safety pledge of 50% reduction in identified harm (falls, medication errors, pressure ulcers) b) Reduction in older people's risk of falling through targeted group exercise programmes and falls risk management interventions resulting in older people maintaining their independence and function c) More consistent, standardised and timely assessment and input to falls risk patients d) Reduction in waiting time for specialist falls assessment e) Closer links with the neighbourhood teams for specialist falls advice and support f) Reduction in pressure on the neighbourhood teams allowing them to provide more timely falls risk assessments and interventions g) Cost savings through the proactive assessment and management of the risk of falls thereby reducing the numbers/level of harm and preventing possible hospital admissions or admissions to community beds or neighbourhood team caseloads (e.g. fractured neck of femur costs £8-20k to health and social care in treatment and rehabilitation) h) Safety Huddles spread across registered and non-registered staff, actively sharing learning to avoid harm

Outcome	The falls enhancements via the iBCF money has not seen a corollary reduction in waiting times as the additional capacity has coincided with a period of demand growth. The waiting list, though, has been generally maintained. Without the additional capacity the waiting list would be significantly worse.

SB63	Transitional Beds
Purpose	To increase the availability of transitional beds in the city of Leeds over the course of the winter period (2017) by utilising the vacant J31 ward in the Beckett Wing at St James University Hospital. To help provide non-acute bed capacity and mitigate the risks associated with the mobilisation period of the new community beds procurement. The aim would be to transfer patients who are medically optimised to this facility for further assessment of need or on-going therapy input. In addition system capacity is constrained during the winter period and therefore this facility will allow capacity for patients to transfer whilst waiting for identified packages of care or longer term placement. Scheme only funded for 2017/18

SB64 & SB65	Trusted Assessors - LGI and SJH
Purpose	The bid for Trusted assessors is to increase the capacity of the Leeds Integrated Discharge Service (LIDS) to enable cover to be extended to wards on the LGI site.
Expected Benefits	a) Reduce the number of delayed transfer of care patients in Leeds – Target <30 per month b) Reduce length of stay – reduce number of stranded patients by 42% by March 2020 c) Increase number of patients referred to reablement service – Target = 14.5% d) Reduction in long term care placements – Target = 18% Nursing Homes, 15% Residential e) Reduce number of MOFD beds in Acute Trust f) Reduce number of patients on sub optimal pathway on discharge – Target = 56% patients on sub optimal pathway
Outcome	a) Actual = 25 – 30 per month b) On target up until November 2019. During the winter period this number has now increased and therefore no longer achieving the trajectory c) 7% increase in referrals Sept 2019 d) Nursing Home = 9% Residential = 8% e) 112 beds remain open f) 41%