**Leeds Integration and Better Care Fund**

**Narrative Plan Template 2017/19**
***Better Care Support Team***
**Version: V1.0**

| | |
|---|---|
| Area | Leeds Health and Wellbeing Board |
| Constituent Health and Wellbeing Boards | Leeds City Council |
| Constituent CCGs | Leeds Clinical Commissioning Groups Partnership |

**Submission summary**

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| Local Authority | **Leeds City Council** |
| Clinical Commissioning Groups | **NHS Leeds South and East CCG** |
| | **NHS Leeds West CCG** |
| | **NHS Leeds North CCG** |
| Date of Narrative Plan | **11th September 2017** |
| Date of BCF Planning return | **11th September 2017** |
| Value of pooled budget 2017/18 | **£76,493,789** |
| National conditions | **Actions and plans to meet national conditions are in place** |

## Contents

## 1. Introduction / Foreword

The Leeds BCF Plan for 2017-2019 builds upon the strong integrated working that has already been put in place in the city, as a result of previous BCF initiatives and the development of both the Leeds Health & Wellbeing Strategy and Leeds Health and Care Plan (Leeds Plan). All of which have been developed in accordance with the Integration and Better Care Fund Policy Framework, local Government Transformation and the context of the NHS Five year Forward View

The vision for Leeds through the Health and Wellbeing Strategy and Leeds Plan is that by 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. It is a plan that will improve health and wellbeing for all ages and for all of Leeds which will

- Protect the vulnerable and reduce inequalities
- Improve quality and reduce inconsistency
- Build a sustainable system within the reduced resources available

The BCF Plan for 2017-2019 underpins the Leeds Plan, focussing on its key workstreams of :

- Prevention – "living a healthy life to keep myself well"
- Proactive Care and Self-Management – Health and care services working with me in my community"
- Optimising Secondary Care – "Hospital care only when I need it"
- Urgent Care and Rapid Response - "I get rapid help when needed to allow me to return to managing my own health in a planned way"

whilst ensuring that the additional funding for social care allocated through iBCF and the Spring Budget monies will be well spent in relation to current local system pressures and supporting development of sustainable services.

The funding contributions and schemes being supported include the continuation of existing schemes from the previous BCF plans. A summary of the use of the additional funding made available through the iBCF and the Spring Budget, totalling £51.5m over the next 3 years, are as follows::

- Prevention/Self Care/Self-Management £ 5.5m
- Reducing Pressures on the NHS £ 7.6m
- Stability of the Provider Market £ 1.0m
- Provision for Leeds Health & Care Plan £ 2.0m
- Demand and Demographic Pressures in Social Care £22.7m
- Reducing/Reversing planned reductions in Social Care £15.3m

The above priorities total £54.1m, however, it is expected that this level of over programming can be managed within the overall allocation of £51.2m over the next three years.

Clearly there is a mix of both recurrent and non-recurrent funding included within the £51.5m above, which has allowed for a mixture of both recurrent and non-recurrent support. For instance, the support to stabilise the local care market identified above is non-recurrent support from the Spring Budget, and further recurrent support is being provided from the Social Care recurrent budget and the recurrent iBCF.

This BCF Plan along with the other related plans has been developed in conjunction with a broad range of 'supporters' and has been signed off by the Leeds Health & Wellbeing Board.

## 2. What is the local vision and approach for health and social care integration?

### Vision

Leeds has an ambition to be the Best City in the UK by 2030. A key part of this is being the Best City for Health and Wellbeing and Leeds has the people, partnerships and placed-based values to succeed in achieving this.

We have a nationally recognised Leeds Health and Wellbeing Strategy 2016-2021 which we are looking to deliver in large part through the Leeds Health and Care Plan (known as the Leeds Plan), our city's place-based component of the West Yorkshire & Harrogate Sustainability & Transformation Plan (STP).

Both the Leeds Plan and the STP result in a set of other initiatives to deliver their stated aims which are described in more detail below. The Better Care Fund plan (BCF) underpins the system and initiatives as indicated in sections 5 and 6.

1. Leeds Health and Wellbeing Strategy[1]

The Leeds Health and Wellbeing Strategy 2016-2021, and has the vision that:

> 'Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest'.

The Strategy has identified five key outcomes which are the conditions of wellbeing we want to realise for everyone in Leeds:

1) People will live longer and have healthier lives
2) People will live full, active and independent lives
3) People's quality of life will be improved by access to quality services
4) People will be actively involved in their health and their care
5) People will live in healthy, safe and sustainable communities.

[1] Leeds Health and Wellbeing Strategy

To achieve this vision the city will focus on twelve key priorities. It is recognised that to deliver many of the priorities the city will need to focus on transforming services including where necessary integrating services to ensure that people with long term care needs are supported to stay well. Other strategies and action plans will be developed to provide further detail on how specific parts of the citywide vision will be achieved over the next five years."

Further, Leeds will continue to change the way it works, becoming more enterprising, bringing in new service delivery models and working more closely with partners, public and the workforce locally and across the region to deliver shared priorities. However, this will not be enough to address the sustainability challenge. Future years are likely to see a reduction in provision with regard to services which provide fewer outcomes for local people and offer less value for the 'Leeds £'.

## Transformation and Integration of Services

West Yorkshire & Harrogate Sustainability and Transformation Plan (WYSTP) Leeds City Council[2]

In recognising the value and potential of more shared working across the region, Leeds has actively worked with other areas of West Yorkshire to develop a shared West Yorkshire and Harrogate Sustainability and Transformation Plan (WYSTP)

The WYSTP is underpinned by six place based implementation plans. The Leeds Plan is the Leeds contribution to the WYSTP and describes how Leeds will deliver the requirements contained within the NHS Five Year Forward View whilst at the same time focussing on local priorities as agreed through the Leeds Health and Wellbeing Strategy

The Leeds Health and Care Plan (Leeds Plan) [3]

The development of the Leeds Plan provides us the opportunity to place the BCF within an overarching longer term strategy and ensure it does not operate in isolation from other initiatives in the city. The Leeds Plan sets out ideas about how we will improve health outcomes, care quality and financial sustainability of the health and care system in the city. The plan recognises the Leeds Health and Wellbeing Strategy 2016-2021, its vision and its outcomes, and begins to set out a plan to achieve its aims.

The plan recognises and references the collaborative work done by partners across the region to develop the West Yorkshire and Harrogate STP, but is primarily a Leeds based approach to transformation, building on the existing strategies that promote health and inclusive growth in the city. Whilst the financial challenge is a genuine one, the Leeds approach remains one based on long term planning including demand management, behaviour change and transition from expensive acute services towards community based approaches that are both popular with residents and financially sustainable.

A transition towards a community focused model of health is intrinsic to the plan through the system integration work. This is the major change locally and will touch the lives of all people in Leeds. This 'new model of care' will bring services together in the community. GP practices, social care, third sector and public health services will be informally integrated in a 'primary care home'. Our hospitals will work closely with this model and care will be provided closer to home where possible, and as early as

[3] A3 Version of the Leeds Health and Care Plan on a Page

possible. New tools, known as ‘Population Health Management’ will be used to ensure the right people get the right services and that these are offered in a timely fashion. This is designed to prevent illness where possible and manage it in the community.

The development of the Leeds Health and Care Plan has been supported by partners and stakeholders from across various health and care providers and commissioners, as well as Healthwatch Leeds, third sector and local area Community Committees (local public meetings led by councillors across the city). Conversations have also taken place over the last year about how best to align the citizen conversation about health and care in Leeds with ‘Changing Leeds’

A significant amount of engagement activity has taken place when the Leeds Health and Wellbeing Strategy was being refreshed. This is alongside ongoing engagement activity on strategic decision making which occurs across the activity of the Leeds Health and Wellbeing Board and its constituent members. All of this has helped shape the Leeds Health and Care Plan.

As statutory organisations across the city working with our thriving third sector and academic partners, we have come together to develop, for the first time, a system-wide plan for a sustainable, high-quality health and social care system. The plan has been improved through engagement with a wide range of stakeholders and will continue to develop through further conversations with citizens. We want to ensure that services in Leeds can continue to provide high-quality support that meets, or exceeds, the expectations of adults, children and young people across the city: the patients and carers of today and tomorrow.

Our Leeds Health and Care Plan is built on taking our asset-based approach to the next level to help deliver the health and care aspects of the Leeds Health and Wellbeing Strategy 2016-2021. It is a plan that will strive to improve health and wellbeing for all ages and for all of Leeds, but where people who are poorest improve their health the fastest. This is enshrined in a set of values and principles and a way of thinking about our city, which:

- Identifies and makes visible the health and care-enhancing assets in a community and sees citizens, families and communities as the co-producers of health and wellbeing rather than the passive recipients of services.
- Promotes community networks, relationships and friendships that can provide caring, mutual help and empowerment.
- Identifies what has the potential to improve health and wellbeing the fastest including what already works well in an area and the opportunities provided by digitalisation to improve connections and promote integration.
- Further develops prevention and early intervention and uses neighbourhoods as a starting point to help integrate social care, hospital, third sector and

community services to provide care closer to home and a rapid response in time of crisis.
- Supports individuals' mental health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships and services working to tackle physical and mental health together.
- Values, empowers and helps grow our own workforce from our diverse communities and involves them in the co-production of any changes.
- Understands the importance of the economy, housing, employment and environment in generating health.

The Leeds Plan has been developed within the context of the Integration and Better Care Fund Policy Framework, local Government Transformation and the need to develop plans within the context of the NHS Five year Forward View and associated publications.

The vision for Leeds Health and Care Plan is that by 2021, Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. It is a plan that will improve health and wellbeing for all ages and for all of Leeds which will

- Protect the vulnerable and reduce inequalities
- Improve quality and reduce inconsistency
- Build a sustainable system within the reduced resources available

The ambition for the Leeds Plan is for our community health and care service providers, GPs, local authority, hospitals and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that:

- Have citizens at the centre of all decisions and change the conversation around health and care
- Build on the strengths in ourselves, our families and our community; working with people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong
- Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens
- Use neighbourhoods as a starting point to further integrate our social care, hospital and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis
- Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do
- Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire

## Models of Care

Population Health Management[4]

Leeds is moving to an approach that focusses on population level outcomes. A system Blueprint for Population Health Management (PHM) has been developed, and is due for sign-off in September 2017. The Blueprint describes our vision and plans for commissioning for outcomes and integrated provision in Leeds, building on Leeds's strengths with regard to partnership working and place-based care. The Blueprint has been co-produced through a process of engagement.

The definition for Population Health Management (PHM) adopted by Leeds recognises that health and wellbeing is more than just being 'without disease'. It moves away from managing disease in silos to an approach based on defined populations of people, who may have multiple 'disease conditions' or life challenges. It provides a framework for the whole population across all age groups.

In Leeds, PHM is described as:

- Improving population outcomes through a whole system approach where commissioners and providers work together to define, measure and improve population outcomes.
- Designing, organising and integrating the full cycle of care around the needs of a population group by moving away from organisational silos towards jointly accountable/local care.
- Supported by a strategic approach to commissioning which measures and values delivery of key outcomes for defined population segments, rather than the traditional emphasis on processes, pathways and activities.
- Fully utilising informatics solutions to direct care interventions to where they are most needed, and better support professionals in joint working.

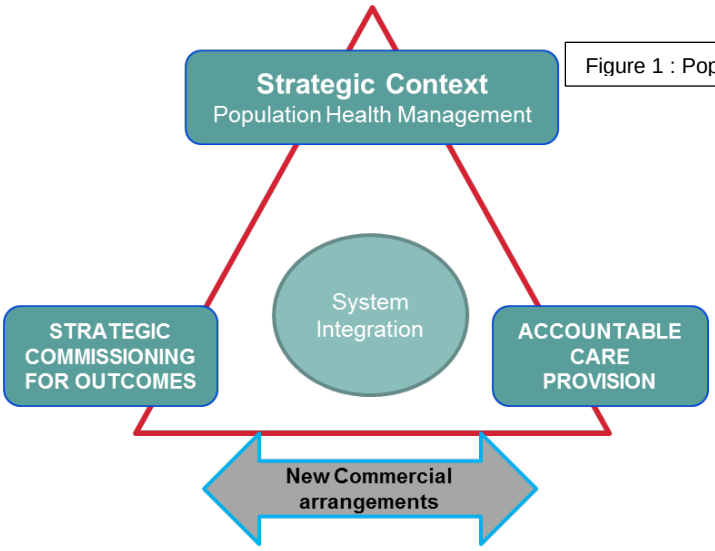



Figure 1 : Population Health Management Approach

[4] Leeds system Blueprint for Population Health Management (not published)

To achieve the vision of the Leeds Health and Wellbeing Strategy and address the three gaps identified within "Next Steps on the NHS Five Year Forward View" (Health and Wellbeing, Care and Quality and Funding and Efficiency) there is a need for Leeds, to simultaneously balance the need to:

1) Continue to deliver pathway level re-design.
2) Actively support new models of joint accountability between providers
3) Co-produce the conditions for providers to work in partnership by adopting a PHM approach focussed on improving outcomes for the population.
4) Approach this by understanding the needs of broad groupings (or segments) of the population and using this understanding to set high level outcomes.

Other Models of Care

In addition to PHM we are aiming to achieve the extended primary care neighbourhood model of health and care delivery with local care partnerships being established.

Across Leeds there are a multitude of new models of care being tested at neighbourhood or locality level. These 'test-beds' have developed, bottom up to respond to local population need. Positive progress in a number of key areas has been made, Living Well Leeds; Primary Care based musculoskeletal services and the Neighbourhood Leadership Model; and provide examples of where good practice can be achieved.

We are also seeing the further development of providers coming together to establish joint accountability arrangement's to respond to gaps in care (for example: GPs in A & E, Extended Access to Primary Care and "Primary Care Home" – enhanced neighbourhood teams.)

Leeds has an opportunity to strengthen governance and strategic plans to drive the level of system change desired. The blueprint proposes a combined 'twin approach' to take forward PHM: System-Led adoption of PHM and Organic, bottom-up Pathway/provider focussed.

The system will deliver a reduction in acute activity (Delayed Transfers of Care (DTOCS), admissions, readmissions, Length of Stay (LOS), excess bed days).

Housing Strategy 2016 - 2021

The Health and Wellbeing Strategy acknowledges that housing is a wider determination of health and consequently needs to be addressed to allow the vison to be realised. The Leeds Housing Strategy sets out our ambition for effectively meeting

the needs of those in greatest housing need over the next 5 years. The vision and delivery of the strategy is to: Effectively meeting affordable and social housing need, promoting independence and creating sustainable communities to make Leeds the best place to live.

The plan to deliver the strategy:

- Neighbourhood Approach – targeting particular neighbourhoods with a wraparound service that meets the wider needs of residents and the neighbourhood, not just the housing need;
- Focus on Prevention – ensuring that suitable levels of support are available from an early stage to enable residents to live confidently and independently in their home;
- Collaborative Working – We have well established and strong relationships with our key partners in order to jointly deliver this strategy;
- Building Community Resilience – empowering communities to support themselves through closer working with community led and third sector organisation.

Six key themes have been identified as priorities within the strategy including: <u>"Meeting the needs of older residents"</u> – Ensuring that the right housing options are available which allow older people to remain active and independent in their homes and communities. To support this a range of key services are available :

- Minor adaptations to homes in all housing sectors to ensure that residents can maintain independence and remain living in their place of choice:
- Hospital discharge service to support residents to return home or to a new home that meets their needs
- Healthy aging programmes offering training and guidance for staff working with communities on issues such as falls prevention, nutrition and hydration and winter wellbeing
- Promoting Social Inclusion by encouraging residents to remain active and link in with community activities, e.g. activities such as lunch clubs, chair based exercise in sheltered housing schemes and the Neighbourhood networks.

<u>Disabled Facilities Grant (DFG)</u>

Leeds is a significant provider of DFG which is a contributing factor in allowing people to return home. Significant demand for this has led to prioritisation of the DFG grant on integrated technology projects that support health and social care professionals in supporting vulnerable adults to retain their independence and remain in their own homes for longer. These include the development and roll out of the nationally acclaimed Leeds Care Record and the development of a unique Person Held Health & Care Record, as well as supporting the delivery of the Digital Roadmap for Leeds.

Local Plans

Leeds has also developed a range of shorter term plans that underpin the WYSTP. Examples include the CCG's Operational Plans and the Leeds A&E Delivery Board Plan.

National Picture

In October 2014, the NHS Published the Five Year Forward View a wide ranging strategy providing direction to health and partner care services to improve outcomes and become financially sustainable. On 22/12/20115, NHS England (NHSE) published the 'delivering the Forward View: NHS Planning guidance 2016/17 – 2020/21.[5]

The BCF contributes to the 12 priority areas which have been identified in the Health and Wellbeing Strategy. Too often care is organised around single illnesses rather than all of an individual's needs. Leeds is focusing on making care services more person-centred, integrated and preventative. All organisations will be working together to achieve this alongside the local communities and individuals. The diagram below illustrates the approach Leeds takes to work together.

Objectives of the Better Care Fund Partnership

The key objective of the Better Care Fund Partnership will be to underpin the priorities outlined within the Leeds Plan with a focus on developing integrated services that proactively support patients to manage their conditions. Our approach aims to deliver the following:-

- Reduce the need for people for emergency admissions to hospital
- Ensure that people only stay in hospital as long as necessary for their care
- Reducing dependency on long term care, residential with or without nursing care
- Maximising community assets

Our Integration and Better Care Fund Plan builds on the work already undertaken within the BCF ensuring consistency with The West Yorkshire and Harrogate STP and Leeds Health and Care Plan (Leeds Plan).

[5] Delivering the forward view: NHS Planning guidance 2016 - 2021

## 3. Background and context to the plan

Leeds is the UK's third largest city with a population of around 750,000. It is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population (2011 census).
It is also one of the greenest cities in the UK with 20 major parks and two thirds of the district as rural.

The population is expected to rise to around 840,000 by 2021, with an increase in the numbers of children of primary age as well as the numbers of those aged over 75 and over 85.

Nationally a 14% increase [6]in the number of people living with dementia is expected between 2016 and 2020, driven by prevalence of the condition in the over 75's and improved diagnosis. This would equate to an increase in numbers living with the disease in Leeds from 8,500 today to 9,600 in 2020-21. However with the emergence of health inequalities as risk factors for dementia the outturn in Leeds could be underestimated.
Dementia-related disability is forecast to increase by 49% in the next ten years (England and Wales), partly because of increasing numbers with the condition and partly increasing levels of need experienced by people with dementia. This emerging trend is already observed by local service providers.

The health of people in Leeds is generally lower than the England average. This is strongly associated with the high levels of deprivation experienced by 150,000 people in Leeds who are living in the most deprived neighbourhoods nationally. Whilst overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds.

The major issues, contributing to lower health and wellbeing, identified in all Leeds JSNA's include: deprivation, mental health, smoking, alcohol, obesity, health conditions such as cancer and cardio vascular disease and dementia, children and young people's health, financial inclusion, housing, social isolation and older people, equality groups and issues for localities.

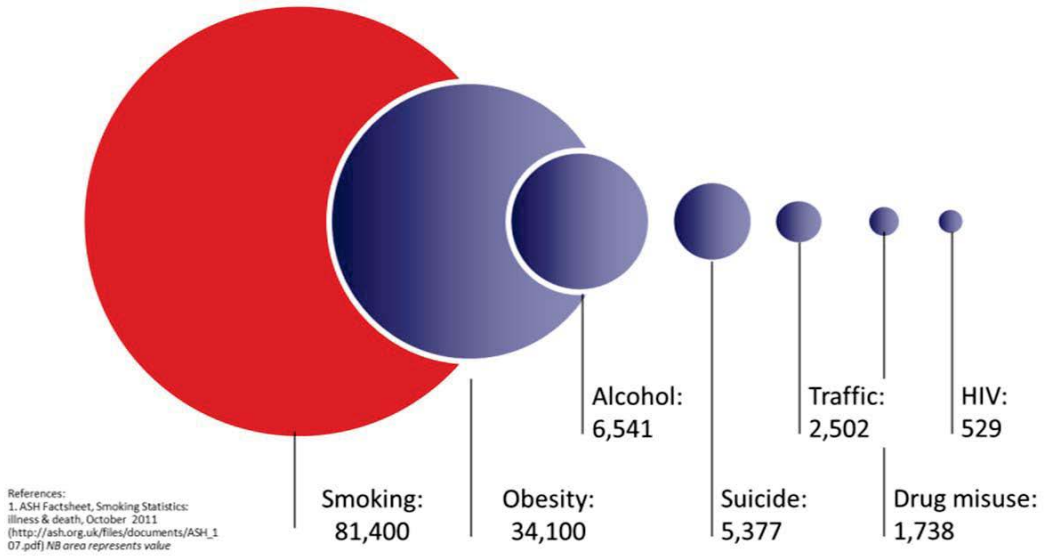
The aging population along with combined with growing number of people living with long term conditions is creating significant pressures on the health and social care system within Leeds. The Leeds system is experiencing demand growth for emergency care of between 2% and 3% per year with acuity of patients increasing as the population increases.

[6] http://www.bmj.com/content/358/bmj.j2856

As more people develop long term conditions, we recognise the need for health and care services to adapt to managing health conditions which empower individuals to manage better their conditions and ensure where appropriate, health and care providers take a proactive care approach.

Long term conditions can lead to a reduced quality of life and premature death, but are preventable. Figure 2 (below) shows the causes of preventable death in England):

Figure 2.




In previous years Leeds has used the BCF to take forward its stated vision for health and social care. Today that vision is driven by the Leeds Plan and the BCF schemes are aligned to it and enable its delivery.

Current State of Health and Social Care Market:

The current state of the Leeds social care market is covered in detail in the Leeds Market Position Statement 2015-18 (revised June 2017). In Leeds we have a diverse and vibrant care and support provider market, with a good mix of third and independent sector organisations, and small as well as larger providers. The mix of providers does differ by type of service, for example preventative services are predominantly delivered by third sector organisations, whereas residential and nursing care services for older people are largely provided by the independent sector. This diversity is positive for the city and provides service users with greater choice. Maintaining a vibrant and diverse market is a priority for us.

Key trends in the market place are the continued move away from residential to supported living provision for working age adults. For older people the preference remains to be able to support people to live independently for as long as possible, with residential provision being required for those with more complex needs.

Key Issues and Challenges

Suitable workforce.

Workforce and Organisational development has been recognised as a key issue and forms one of the enabling workstreams under the Leeds Plan.
Locally the recruitment and retention of nursing staff within public sector organisations remains a challenge and has the potential to be exacerbated by European nationals leaving due to Brexit and its associated uncertainties.,

Allied to this is a demographic challenge around local General Practitioners, where a number are approaching the age where they could elect to take early retirement which would place a significant capacity restraint on the healthcare system.

Leeds is a signatory to the Ethical Care Charter which recognises the value of care staff and the promise of a living wage. This has been incorporated into new care contracts awarded by the Council in June 2017.

Funding

Funding of both health and social care remains a significant concern. In Leeds a significant portion of the Spring Budget iBCF funding allocation will be used to reverse/obviate the need for budget savings that would otherwise have been inevitable. These would have had a significant impact on care packages and the funding of our nationally recognised preventative services, including the older people's Neighbourhood Networks and community mental health provision. Such budget savings, equivalent to around 500,000 hours of home care or 15,000 care home bed weeks, would have had a serious impact on Leeds citizens ready for discharge from hospital and on DTOC metrics

## 4 Progress to date

Leeds City Council and Leeds Health Commissioners have a long history of joint working to support the development of out of hospital care. The city has well established integrated health and social care teams based on localities.

To date Leeds BCF Plans have included a range of initiatives designed to provide better health and care services, closer to home, with the aim of reducing the demand

for urgent and emergency care and the need for expensive hospital beds and residential care home placements. This was extended in 2015/16 to cover plans for out of hospital care.

The BCF has funded a number of initiatives and services that collectively support people to live independently in their own communities and reduce people's need for hospital-based care including :-

- Reablement services
- Supporting Carers
- Leeds Equipment Service
- Falls prevention
- Enhancing Integrated Neighbourhood Teams
- Community Matrons
- Expanding Community Intermediate Care beds
- Urgent Care Services
- 3rd sector prevention
- Admission avoidance
- Disabled Facilities Grant
- Enhancing Primary Care

Whilst we have successfully implemented our initiatives they have not to date had the impact that we had hoped in certain areas (eg. Non Elective Admissions (NEA)). In particular the demand for emergency care has continued to rise, with the Leeds health and social care system experiencing similar issues to those across the majority of the UK i.e. increasing numbers of A&E attendances and emergency admissions, ongoing non-delivery of the A&E 4-hour standard and cancellation of elective surgery leading to non-delivery of the referral to treatment and cancer 62-day treatment standards.

<u>Other Health and Care Integration</u>

In addition to all the integration activities described in section 2, together, and separately both the Local Authority and CCG's have moved towards closer integration. From April 2017 Leeds City Council brought all its 'people commissioning' functions together into the Adults and Health Directorate, and the formation of the Leeds Clinical Commissioning Groups Partnership across the Leeds CCG's supports integration begun with the "One Voice Programme" which established a single leadership team across the three CCG's and streamlined commissioning functions through:

1. Establishing a Strategic Commissioning function, integrating previously separate commissioning teams and functions.
2. Establishing a System Integrator (SI) function to proactively establish a PHM approach by facilitating a move to commissioning for population

level outcomes alongside the development of providers to delivery level outcomes through accountable care arrangements.

At the same time, providers across the city are working together more closely than ever before through the Leeds Provider Network which includes representation from all providers including the Third Sector and General Practice.

The commissioners and providers in Leeds are signed up to making System Integration happen and the Health and Wellbeing Board, and the Partnership Executive Group (PEG) have committed to the change.

CCG Operational plan

In December 2016 Leeds CCG's submitted their two year operational plans. These plans outline the CCG's service and financial plans for the period 2017 – 2019. The plans provide assurance to NHS England as to how CCG's will meet key national priorities over the period along with details on the alignment of the CCG's plans with the priorities identified by the wider health and care system such as the West Yorkshire and Harrogate STP and the Leeds Plan.

The CCG Operational Plan includes the CCG finance and activity trajectories for Non-Elective Admissions (NEA's).

In July 2017 the CCG activity plans were recalibrated to take account of changes with national categorisation of services between NHS England and CCGs.

The CCGs are confident that their Non Elective plans are robust and affordable; they have been signed off by NHS England as part of their assurance process. As such the BCF submission for Non-Elective Admissions will be consistent with those of the CCG.

Former National Conditions

Leeds continues to work to those BCF national conditions that were stipulated in 2016/17 but which NHSE have not carried forward as formal BCF conditions for 2017/18 and 2018/19:-

**Delivery of 7 day services** – agreement for the delivery of this is still in place following the improvement from an 'in-progress' position in Q3 2016/17. The Leeds Transfer of Care Group, under the auspices of the Leeds A&E Board, is responsible for continued delivery of the 7days principles through Leeds' implementation of the High Impact Change Model.

**Better data sharing** – Leeds continues to use the NHS number as a common identifier. We have a proven track record of interoperability between systems, as

evidenced by the Leeds Care Record. The use of APIs remains a key strategic principle. We have now established a joint Local Authority and CCGs' Integrated Business Intelligence service which is driving this agenda further. We continue to ensure that our Information Governance remains in line with revised guidance and to keep the public aware of their rights in this respect and informed of how their data is used.

**Joint approach to assessment and planning** – Leeds continues this approach through its investment in the further development of the Leeds Care record. The newly established Leeds Integrated Discharge Service (LIDS) streamlines and accelerates the transfer from hospital care to appropriate community services. The Trusted Assessor approach, driven through the High Impact Change Model has led to an upskilling within the hospital, with a joint approach towards assessment for the enhanced Reablement Service (four hour at home response for hospital discharges).

**Consequential impact on providers** – the overall Leeds Plan approach and governance is joint between Health and Social Care commissioners and providers. This allows individual projects to be worked through in terms of unintended consequences and ensures that actions do not destabilise providers or effect service delivery to Leeds citizens.

## Performance Against Key Metrics

### Non-elective admissions (NEA)

Performance against the NEA target continues to be a challenge. Our aim of stemming growth in non-electives is proving difficult. The nationally reported figures, as derived from SUS, appear to show considerable growth. However, this does not reflect the realty as the national figures do not take account of local coding changes. Leeds has over the last two years changed the way it codes those patients admitted to the Clinical Decision (short stay assessment) Unit from A&E. The table below outlines growth with and without the inclusion of the change of coding i.e. those patients admitted under the A&E specialty to the Clinical Decision Unit

| Financial Year | Activity | A&E Coded Activity | Activity Net of A&E | Activity Growth including A&E % | Growth without A&E admissions % |
|---|---|---|---|---|---|
| 2014/15 | 66673 | 7087 | 59586 | | |
| 2015/16 | 71772 | 10707 | 61065 | 7.6% | 2.5% |
| 2016/17 | 77112 | 16210 | 60902 | 7.4% | -0.3% |

Once these changes are taken into account our growth rate is much lower and shows a growth of 2.5% in between 14/15 and 15/16 and 0% in the last financial year (16/17). This reduction reflects significant work undertaken to change ambulatory care pathways with a focus on avoiding admissions.

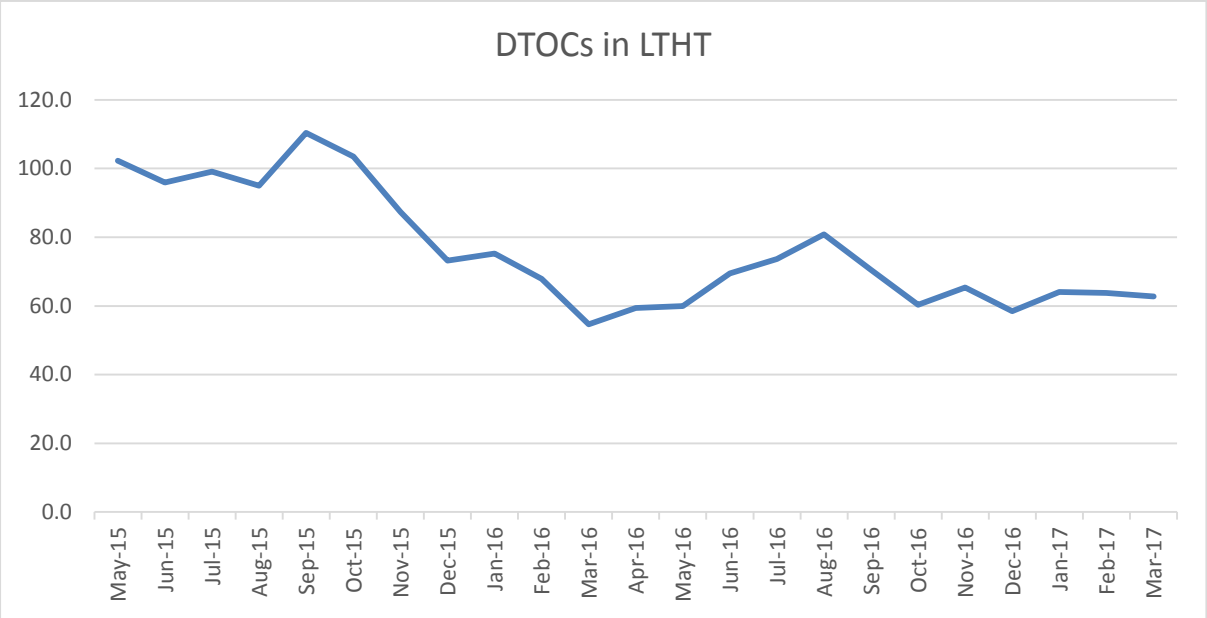
It should be noted that whilst recorded admissions are showing a year on year decrease there remains significant pressure for beds. In recent years the total number of non-elective bed days has grown year on year in line with that expected by demographic changes i.e. around 2%. It is this growth in bed usage that is placing significant pressure on local NHS Hospitals.

The aim for 2017/18 is to maintain the impetus on avoiding admissions through changes in front door A&E streaming and through increasing focus on proactive community management of patients with Long Term Conditions.

**Delayed Transfers of Care (DTOC)**

In Oct 2016 Leeds established an integrated discharge service on 10 acute medical wards. The table below describes the progress the Leeds system has had with respect to reducing the number of delayed discharges in Leeds Teaching Hospitals

The average number of beds occupied by DTOCs has remained relatively stable for the last year. The table below shows that the number beds occupied by DTOCs in any given month has dropped from around 100 in July 2015 to its current level of around 62.




To date our focus has been on maintaining levels of DTOCs in our main teaching hospital. In 2017/18 we will continue to undertake initiatives to support LTH along with focussing harder on other providers.

Our current target is to reduce average DTOCs from around 83 across all providers to an average of 59 DTOCs per day (based on weekly DTOC bed days/7). This would constitute around 25% reduction as compared to the current levels. Plans in place to address current levels include

a) Maximising potential of new reablement service (live June 19th 2017)
b) Implement new Community Beds Strategy Inc Transfer to Assess
c) Build Trusted Assessor Capacity in Integrated Discharge Service
d) Build on current Care homes Initiatives
e) Improved streaming in A&E to avoid admission
f) Renewed focus on supported choice
g) Focus on DTOCs related to mental Health Issues

Successes
Over the last two years Leeds Health and Social Care system has had some success in reducing the number of DTOCs in Leeds Teaching Hospitals. There are a number of reasons for this which include.

a) Improved multi agency working between health and care systems
b) Implementation of new Leeds Integrated discharge Service went live on 9 wards in Leeds teaching Hospitals in November 2016
c) Improvements in system escalation and mutual aid processes when the system is under pressure

Over Q4 of 2016/17 the levels of DTOCs in LTHT remained fairly consistent at around 62 per week. Whilst this is an improvement on recent winters it remains above our target of 47 for the Trust

We are currently working to build on our work to date to improve further our multi agency working and systems responses to further reduce DTOCs

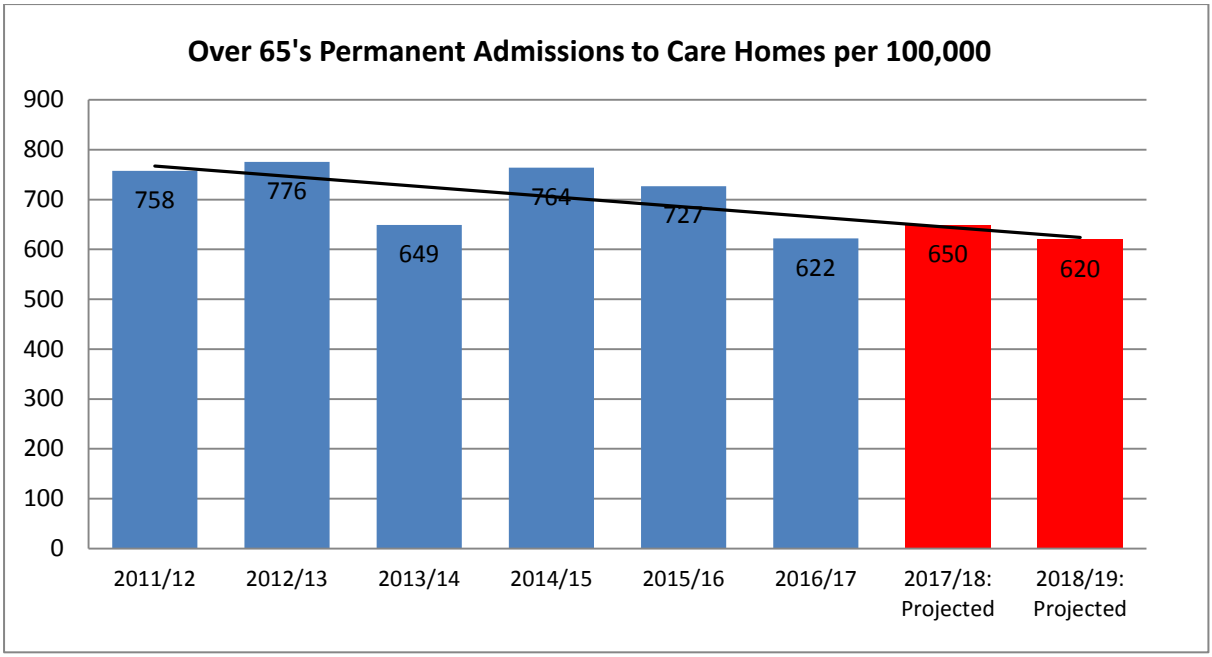
Rate of Admissions

The ASCOF measure looks at the number of admissions in relation to the estimated older people population for the LA. As the population estimates are changed each year by the ONS this measure does factor in and reflect estimated demographic changes.

The BCF target for 2016/17 was 750.4 admissions per 100,000 over 65 (910 actual). The outturn was well below this at 622 admissions.

Top quartile performance for 2015/16 was between 513.3 and 188 admissions per 100,000. The all England average was 628 and the comparator average 760.

The graph below includes conservative projections for 2017/18 and 2018/19 based upon recent trends and should the current direction of travel continue and self-funders continue to be excluded.




Effectiveness of Re-ablement

Skills for Independent Living (SkILs) is Leeds City Council's home care reablement service which has been developed from what was the Council's in house home care service. SkILs became a city wide service in January 2012 and the service been under continued review and changes made since its introduction with a major restructure and change in the route through the service, though not to the customer group it is focussed on, implemented in June 2017.

Homecare reablement is seen as a key service to support system flow – with a particular focus on the service facilitating discharge from hospital where the person has an opportunity to make further recovery but does not require clinical interventions.

The majority of the budget is spent on staff, with £3.8m on the front line support workers. The delivery of the service is supported in operations by senior support workers, case officers and managers. There is also a business support team which is critical in managing the rostering of staff and ensuring visits to customers are carried out and collecting and reporting on service performance. The service is registered with CQC and has recently been inspected and was found to be "Good" on all domains.

The Needs Identification Tool (NIT) was introduced in June 2017 as part of the new service model which involves Case Officers from the service visiting the person referred to reablement and carrying out an assessment and identifies the individual's

potential to benefit from the service and if so, leads to creating a Personal Outcomes Plan. Previously in the Leeds service, the assessment and outcomes were designed by the health or social care assessor making a referral to the service, but issues with flow – described below – led to the redesign of the pathway to get people into the service more efficiently.

The service has a Budget Action Plan every year and is also reported on through the Leeds Adults and Health Social Care Performance and Outcomes Framework.

The latter reports the following performance for 2015/16 and 2016/17

| Measure | | 15/16 | 16/17 |
|---|---|---|---|
| 10 | The number of people starting a service | 1532 | 1827 |
| 10a | The number of people completing a service | 1363 | 1717 |

The reporting for 2017/18 has been complicated by a change of service model at the end of quarter 1. While the new model is not designed to change the eligibility of people who receive reablement, it is designed to identify more of those people who do meet the entry criteria, get them into service and move them on at the end of the intervention more quickly.

The Targets for starters and completers in 2017 is

Starters 3,427

Completers 3,060

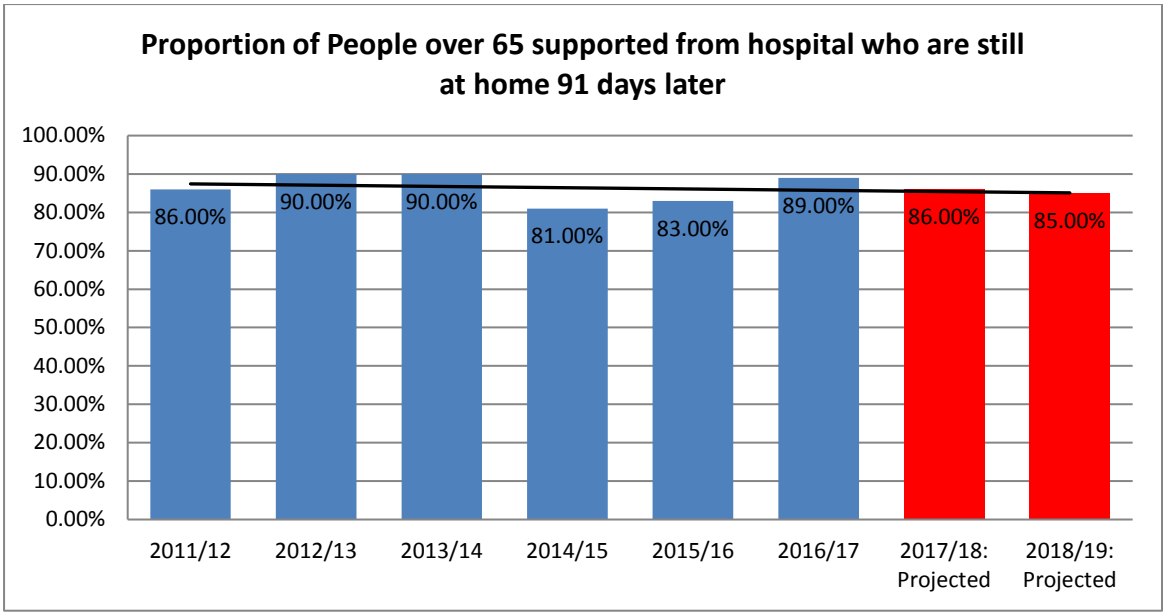
The benefits expected from the redesigned service are detailed in section 11.

**ASCOF Measure 2B(1): Reablement – Proportion of people over 65 supported from hospital who are still at home 91 days following discharge**

This ASCOF measure includes people who have completed reablement and a check has been undertaken by SKiLs staff 91 days following completion. In addition data is obtained through Caretrak. This includes people with social care involvement leaving hospitals that are further supported through ICT. Caretrak looks for any hospital, residential or other activity up to 91 days after discharge.

The target for the BCF 2016/17 was 92.5%.

Top quartile performance for 2015/16 was between 88.6 and 100%. The all England average was 83% as was the comparator average.




## 5. Evidence base and local priorities to support plan for integration

The aim for the BCF Plan is to underpin the Leeds Plan and address the challenges and issues detailed in section 4. The BCF Plan for 2017-2019 builds upon and learns lessons from our experiences delivering previous BCF Plans.

Key successes

1. Building on partnership work across health and social care with commitment across agencies to follow this through into the STP programme
2. Safeguarding social care and 3rd sector service provision
3. Further development of IT systems across health and social care
4. Development of the Leeds Care Record
5. The Community Intermediate Care bed strategy

Key challenges

1. Aligning BCF expectations and strategic outcomes to pre-existing service developments and the Leeds transformation programme
2. Lack of time to see some pilot projects through to full completion and lack of clarity of the strategic outcomes expected from some pilots.
3. Reducing NEAs
4. Managing the impact of NEAs on the wider system flow

BCF update:

The BCF has helped sustain levels of service delivery during challenging times where the system has seen an increase in people with complex health needs accessing the NHS. Although we have not been able to meet our targets on NEAs, the BCF programme has helped to strengthen our out of hospital care sector which has had a positive impact on other indicators relating to hospital admission. We have also sustained and improved implementing new ways of working across services that has had a positive impact on people's lives.

Whilst demand for services is within our expected demographic profile, all services are seeing a rise in the complexity of the cases presented and this has had an impact on system flow.

Emergency admissions to hospital provide a proxy measure for the impact of these schemes on achieving the stated objective of reducing the need for hospital-based care. Whilst Leeds has not achieved its ambition of reducing all emergency admissions by 3.5% during 2015, this headline masks some notable improvements, particularly in relation to reducing the numbers of patients who stay in hospital one or more nights following an emergency admission (where admissions have seen a significant reduction of 0.03 admissions per 1,000 patients per week over the first three quarters of FY15/16.) Furthermore, Leeds has seen a reduction in the numbers of people accessing A&E services. These reductions are consistent with improvements in how the wider system is delivering out of hospital care.

In line with BCF guidance, the Delayed Transfer of Care (DTOC) metric has been used as an indication of whether the plan for 2015/16 has delivered on this objective. Whilst bed days lost associated with DTOC increased during Q1 and Q2 of FY15/16, this deteriorating position can largely be attributed to improvements in the identification of patients who met the DTOC definition. This is consistent with total occupied bed day data, which demonstrates bed occupancy for emergency admissions to hospital has been remarkably stable for the last six years.

Emergency admissions to hospital data indicates that for the last couple of years re-admissions have been approximately 11 patients per 1,000 population (for people who had 2 or more admissions in the previous 12 months). These represent the lowest rates for the past six years. Similarly, the numbers of people having two or more A&E attendances within a 28 day period has remained stable (at 1.8 patients per 1,000 population) for the past six years. Whilst these measures do not in themselves indicate what proportion of re-admissions might be avoided if out-of-hospital care were optimal, they provide assurance that efforts to discharge patients in a timely way has not negatively impacted re-admission or re-attendance rates. The proportion of people who receive reablement services following discharge from hospital and are still at home after 91 days post-discharge increased to 92%. This represents an improvement

on the previous year's comparator and national average and is deemed a good level of performance for the city.

Our most significant area of success during 2016-17 is the development of the Leeds Care Record. This is now a well-established technology facility across the city that enables the sharing of clinical information between those health and care professionals that are providing direct care to an individual. Those organisations participating are; Leeds Teaching Hospitals, Leeds Community, Leeds and York partnership trust, adult social care, children's services, all GP Practices in Leeds, hospices in Leeds and Yorkshire Ambulance Service. It is actively used by over 4000 health and care professionals.

The Leeds Care Record has been shown to improve clinical decision making, increase the speed by which patients are discharged from hospital and significantly reduced the time making phone calls between organisations. Good feedback has been received from users showing how patients are benefitting from this integrated information. It is a good example of where money has been invested and savings are being made recurrently.

Another significant area of success is our strategy around Community Beds. Longer term commissioning investment has been secured to improve and enhance community bed-based capacity, in readiness for winter. Capacity will be increased from 179 beds to 227 beds (factoring in demographic growth up to 2019/20). The beds will cater for both Intermediate Care and a new Transfer To Assess model. The capacity will meet existing demand as well as meeting the needs of:-

- Additional patients from the community who can't access a Community Bed due to lack of capacity (equivalent to 158 admissions avoided per year)
- at least 50 patients currently waiting in hospital for residential or nursing beds based on Medically Fit For Discharge Data; excludes patients waiting to go home or for complex care - equivalent to 12,500 hospital bed days per year and 4500 excess bed day payments.

A 'hospital to home' service has been maintained but has been integrated further into an Integrated Discharge Service within LTHT working with Discharge Nurses, Therapists and hospital Social Workers. The service continues to evolve and ongoing development reports into the System Resilience Governance.

The biggest challenge we have faced is reducing non-elective admissions and managing the impact of NEAs not reducing. Whilst a change in coding practice in the Acute Sector has impacted on this, we also know that underlying growth is a contributing factor.

The BCF Plan for 2017-19 largely continues with the initiatives from previous years, building on successes, addressing challenges and increasing capacity and reach.

**iBCF**

The strategic direction that the city of Leeds has mandated Adult Social Care to take is to maximise the independence of its citizens through a preventative strength-based approach to social care and linking people to the existing assets in their own communities. Everything is geared towards ensuring that people's independence is maximised and thus their reliance on statutory services is minimised with a focus on:-

- Maximising people's potential through recovery and re-ablement
- Maximising the benefits of existing community assets and Neighbourhood Networks
- Improving the application and uptake of technology

One intended outcome of this strategy is that the demand for home care packages will be levelled or even reduced by directing the service towards people with more complex needs (yet requiring more hours individually), and the demand for care home placements will be levelled by maximising the time that people can be supported in the community. The metrics stipulated by DCLG for the iBCF returns are therefore at odds with this. Indeed, we would view a reduction in these metrics as a sign of success. We recognise that these metrics have been selected at a national level based on an assumption that all areas would view the funding of more care packages as the route to improved system flow and, in particular, reduced DTOCs. However, the funding of these packages is not an obstacle to system flow in Leeds and our investment in improving DTOC performance will focus on the agreed priorities identified through the HICM as detailed above. We are pleased therefore that you have recognised local variation such as this by inviting us to use local metrics that better reflect what we aim to achieve in Leeds whilst still satisfying the purpose and conditions of the grant. We are therefore adopting metrics of:-

1. number of bed weeks residential/nursing care commissioned (as opposed to the number of placements in residential) and
2. number of home care hours relative to residential (non-nursing) care bed weeks

## 6. Better Care Fund plan

### BCF Funding for 2017 - 2019

The BCF allocations for 2017/18 and 2018/19 are shown below. These figures represent increases of £3.2 million and £10.2 on allocations last year. Funding contributions have been agreed between the Council and the CCGs as follows:

| | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|
| Total Local Authority Contribution (exc iBCF) | £9.1m | £9.3m | tbc |
| Total Minimum CCG Contribution | £51.2m | £52.2m | tbc |
| Total Additional CCG Contribution | £0 | £0 | tbc |
| iBCF Contribution (recurrent) | £1.5m | £12.6m | £22.7m |
| Spring Budget Monies (non-recurrent) | £14.7m | £9.5m | £4.7m |
| Total iBCF Contribution | £16.2m | £22.1m | £27.4m |
| **Total BCF pooled budget** | **£76.5m** | **£83.6m** | **tbc** |

The BCF allocation will be spent in these sectors

| | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|
| Acute | £10.4m | £10.4m | TBC |
| Mental Health | £5.8m | £5.8m | TBC |
| Community Health | £20.5m | £21.0m | TBC |
| Continuing Care | £0.3m | £0.3m | TBC |
| Primary Care | £2.1m | £2.1m | TBC |
| Social Care | £37.2m | £43.8m | TBC |
| Other | £0.2m | £0.2m | TBC |
| **Total** | **£76.5m** | **£83.6m** | **TBC** |

The Leeds Better Care Fund pooled budget comprises eleven schemes organised into two funds. Fund 1 contains services whose commissioning is hosted by the Leeds CCG partnership and Fund 2 contains services whose commissioning is hosted by Leeds City Council.

Table below –overview of commissioned schemes in the Leeds BCF

| Pooled Fund | Scheme | Description and impact |
|---|---|---|
| Fund 1: CCG funded services | Mental Health | Transformation of mental health services is aligned to the Leeds Mental Health Framework and the National Five Year Forward View For Mental Health. Commissioners and providers are closely linked to improve mental health services for patients through transformative working. A key example is work to reduce the numbers of out of area placements of mental health patients and the services we provide locally for patients suffering a crisis in their mental health. |
| | CCG Community & Third Sector Service | Third sector and statutory community services that provide support and care:-<br>• within the thirteen integrated Neighbourhood Teams<br>• for people with physical and sensory impairments<br>• for people in housing need/NFA awaiting discharge from hospital<br>• for people experiencing bereavement<br>• Services that prevent unplanned hospital admissions and facilitate timely discharge.<br>• Pro-active care planning with individuals so that contingencies are in place |
| | Community Beds | Intermediate care beds with a range of providers. New contracts start 1st November 2017/18 and see the implementation of a |

| Pooled Fund | Scheme | Description and impact |
|---|---|---|
| | | recommissioned and expanded model that combines bed-based transfer to assess and intermediate care beds. |
| | Enhancing Primary care services | Primary care developments with the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding is used to enhance services to support the management of this patient cohort. |
| | Admission Avoidance-Marginal Tariff/NEL | A number of initiatives including Integrated Discharge Service, assessment units discharging to re-ablement rather than admission. |
| | Information Technology | Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements. |
| Fund 2: Council Hosted Services | South Leeds Independence Centre | LCC –commissioned integrated intermediate care bed-based service until end October 2017 when this is repurposed under the general Community Beds service above. |
| | Leeds Community Equipment & Telecare Service | Revenue streams for this service. |
| | ASC Community & Third Sector Services | Third sector services including support and respite for carers. Contribution to the LCC Re-ablement Service which in 2017/18 is enhancing its service to provide a four hour response time from notification of hospital discharge to home. |
| | Central Allocations | Protection of social care including contributing to the cost of packages of care and the financial costs associated with the Care Act. |
| | Disabled Facility Grant | Means-tested grant to cover the cost of housing adaptations that help disabled people to live independently in their own homes |

For detail of the individual services within the schemes, please see Appendix 1

## Schemes and Impacts

The Leeds Better Care Fund Plan is a contributor to Leeds' wider plans for health and wellbeing and system integration.

Whilst ensuring that the Leeds BCF-funded initiatives meet the relevant BCF grant conditions, the Leeds Plan provides the strategic context for prioritising the spend and also takes account of the actions needed to deliver the High Impact Change model. Leeds is targeting its BCF funding at initiatives that the city has collectively identified, with Leeds City Council and the Leeds CCGs Partnership agreeing proposals with local NHS commissioners via the joint Leeds BCF Partnership Board.

Viewed in this context the BCF will support the Leeds Plan programmes and enablers as follows:

**Prevention**:

Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens.

a) City Wide Health Living Services that target prevention on those populations with the poorest health and therefore greatest opportunity for improvement will

be reprocured by LCC Public Health services. We will target populations with high levels of smoking, obesity and substance misuse to ensure that we reduce the associated harm and address health inequalities.

b) We are continuing with our locality based working and initiatives, to address the broad issues that contribute to health inequalities. We will have a new, locally-based community service, 'Better Together', that can better build everyday resilience and skills in our most vulnerable populations.

**Proactive Care and Self-Management**:

Over the next three years we will change how services are delivered so they are focussed on supporting people to manage their own health and keep as well and independent for as long as possible. We want to help our local health and care economy spend less than it currently does overall by re-distributing this money to services that focus on prevention, self-management and proactive care in the community – GP surgeries, district nursing services, social care services, as well as voluntary/charitable organisations that are such an important part of our city.

a) Self-Management: Systematic implementation of the House of Care framework, as the integrated approach to embedding supportive self-management for physical and mental health LTCs (inc. dementia).

b) New Models of Care: CCGs and NHS Providers are working with Leeds City Council to progress a number of pilots across Leeds to assess potential future models for the integration of primary and community care around natural communities. The aim is to provide seamless care closer to home that maximises opportunity for patients to stay well whilst minimises the duplication of demands across a range of health and social care provision.

*c)* Maximise the potential of Neighbourhood Network Schemes, these are community based, locally led organisations that enable older people to live independently and pro-actively participate within their own communities. They provide services that reduce social isolation, provide opportunities for volunteering and act as a "gateway" to advice/ information services, all to promote the health and wellbeing and thus improve the quality of life for individuals. Internationally recognised.

*d)* Community Bed Strategy: including Transfer to Assess: Leeds CCGs have developed a new strategy for community beds which has been procured and will be operational from 1 November 2017. The strategy builds on evidence of population need and will provide 227 step up/step down beds to ensure that patients either do not need to be admitted to a hospital bed or can be discharged from hospital into a community setting at the earliest possible stage in their recovery, including having their needs assessed. This will support all partners in Leeds in their ability to ensure that patients are provided with the most appropriate out of hospital care for their needs. The service includes a

commitment to adopt the Trusted Assessor approach to bring further efficiencies

e) Home Development: The city is working in partnership on a range of initiatives to include providing clinical support and training to care homes to avoid admissions and expedite acute discharge (both physical and in the form of telecare). There is also significant work being undertaken to ensure that our market Care development strategy across health and social care supports the future development of the care sector in line with changing demographic needs. The quality of care in the care homes sector has also been highlighted as an area of need this year and the council and the CCG are working collaboratively to improve and monitor the quality of care delivered to patients in care homes.
f) Right Care: Leeds CCG are working on a number of pathways where there is evidence that our approach to managing conditions in primary and community care is leading to increased non-elective demand on hospitals beds. The key pathways for 2017/18 are respiratory and cardio vascular disease.
g) Social Prescribing: Leeds CCG and the City Council operate a number of social prescribing initiatives which seek to support patients that may have needs that are not directly health related but impact on demand on health services. These services generally operate as a referral services whereby NHS and Social Care professionals can refer patients for support with issues such as social isolation, housing, benefits and other needs. In 2017/19 Leeds CCGs are seeking to review the social prescribing models currently in operation across Leeds CCGs with the aim of procuring a single citywide model.

**Optimising Secondary Care**

This is a broad ranging project which focusses on both hospital internal efficiencies as well as how the system supports those efficiencies, ensuring that once patients are admitted they are treated in the most cost effective way.

a) Development of the Leeds Integrated Discharge Service: This is one element of the Leeds approach to the delivery of the 8 High Impact Changes. It operates in such a way as to embed a number of the key principles e.g. Integrated Teams, Trusted Assessor, Choice and Early Discharge Planning.

**Urgent Care and Rapid Response**

This programme of work will look to deliver improvements in four areas.

a) Access: a review of all the single points of access across the city and how patients and the public are informed about and access urgent care services, from Ambulance services, community services, urgent primary care, walk in services and A&E.
b) Assessment of patients early in their urgent care journey is critical and delivers best results for patients when done with a multidisciplinary team approach. The programme will look at all the current assessment pathways aiming to make improvements to their efficiency and patients experience.

c) A system wide strategy for urgent care services is in progress across Leeds and this is being linked into the Leeds Plan. The development of GP new models of care and emergent hubs along with extended access is setting the bedrock for a robust urgent care system in Leeds with the strategic direction being to deliver on the NHS aspirations to have Urgent Treatment centres within leeds, open 24 hours a day for walk in, diagnostics and urgent presentations.

In addition the programme will support several other key projects in the City supporting patients presenting with an urgent need:

d) Redesign of 999, 111 and Ambulance Response services: The review and redesign across West Yorkshire seeks to streamline the mechanisms by which patients access services and identifying the most appropriate services to their needs to avoid unnecessary deployment of ambulance and/or attendances at A&E and admission. This includes initiatives such as hear, see and treat and referral to community services, rapid response teams or primary care
e) Frequent Attenders Project: A project that reviews those patients that are high users of urgent care services (e.g. 999 and A&E) whose needs could be managed proactively with greater support in community settings
f) GP Streaming in A&E: Many patients attending A&E could be adequately seen by a primary care service. Leeds has been testing a model where GP's and primary care streaming is delivered within the two A&E units in Leeds. This is in line with National specification.
g) Frailty Service: Health and Social Care leads have developed an innovative frailty assessment service that has been piloted and will be evaluated. Elderly patients are able to be assessed by a team of professionals specialising in elderly care. Evidence from across the UK suggest that such services support admission avoidance through better understanding and management of the needs of frail patients

<u>Information Technology</u>

During 2017/18 the intention is to use Better Care Funds to further increase the use of the Leeds Care Record and enhance its facilities. The following targets have been set; Increase active usage by another 2000 users, increase the adult social care data that is shared, introduce alerts and notifications to make the system more proactive, improve the patient summary to make key information easier to find, to start 'writing' information in to the record rather than simply displaying information collected elsewhere, increase the medical images available, integrate with an emerging Person Held Record. Progress against these targets will be actively monitored.

Person Held Record

Whereas the Leeds Care Record is a multi-organisational, shared-technology facility to support health and care professionals (doctors, nurses, social workers etc.) it is

recognised that, to improve the whole health and care system and improve overall health and wellbeing, citizens and patients need to have greater awareness and understanding of their needs in order to take more control.

Through access to existing health/care/wellbeing information from across the system and the ability to record information to help inform care professionals and their own needs, it is envisaged that citizens will become more informed and proactive in their care needs and self-management (medications, allergies appointments, letters, care plans etc.).

Using Better Care Funds, Leeds is looking to begin the development of such person-held facilities in a way that establishes standards for such facilities across the NHS. For example, how a patient identifies themselves securely and unambiguously on to a digital facility should be standard across the NHS. We are also aiming to undertake this in such a way so as to encourage software developers to follow such standards to give patients/citizens as much choice as possible around the technology they choose to use. In the first instance, we plan to develop a facility to be used by around 300 diabetic patients in Leeds to record certain information about their own care, share some of this with the Leeds Care Record and receive some information from those professionals that look after them. Leeds will also be collaborating with NHS Digital and Cabinet office (Government Digital Services) to showcase both national verification initiatives and a showcase exemplar of a PHR, aligning with paperless 2020 ambitions set by the Secretary of State.

**iBCF**

The iBCF increases announced in the 2015 Spending Review are being utilised to maintain the provision of Social Care Services in Leeds and are therefore funding demand and demographic pressures, particularly in relation to supporting people with a Learning Disability, as well as the impacts of inflation and the National Living Wage. These pressures amount to an annual pressure of in excess of £12m on the Adult Social Care Budget. The ongoing cost of care is currently being reviewed in conjunction with local care providers and it is anticipated that an above inflation increase will be required. This will need to be funded on a recurrent basis from within the iBCF allocation.

**Spring Budget Monies**

Leeds is primarily adopting a sustainable ‘invest to save’ approach in its use of the Spring Budget funding with a focus on managing down the forecast increases in the level of demand for funded home care packages and residential/nursing placements. This will allow us to fund and monitor the impact of initiatives which contribute to the transformation of the Leeds Social Care and Health system (as articulated in the Leeds Health & Care Plan). This is a sustainable approach over the next three years that will help to us mitigate against future demand pressures from 2020/21 onwards after

the additional iBCF funding reaches its peak and the Spring Budget funding has ceased.

Leeds is targeting its additional Spring Budget funding at initiatives that the city has collectively identified will deliver the stated objectives of iBCF. For both the Spring Budget and iBCF allocations, Leeds City Council has worked with the Leeds CCGs Partnership (the new organisational form of the three Leeds CCGs) and proposals have been agreed with local NHS commissioners via the joint Leeds BCF Partnership Board. This allocation has then been reviewed at both System Resilience Assurance Board and Partnership Executive Group.

£8M of Leeds' £14.7M 2017/18 Spring Budget funding allocation will be used to reverse/obviate the need for budget savings that would otherwise have been inevitable. These would have had a significant impact on care packages and the funding of our nationally recognised preventative services, including the older people's Neighbourhood Networks and community mental health provision. £8M equates to around 500,000 hours of home care or 15,000 care home bed weeks. Such budget savings would have had a serious impact on Leeds citizens ready for discharge from hospital and on DTOC metrics.

With the remaining £6.7M, we have prioritised the following initiatives:-

- Falls prevention service
- Enhancement of Neighbourhood Networks
- Capacity to implement the strengths-based approach to Adult Social Care
- Enhancement to Leeds Community Equipment and Telecare Service
- Retaining care home capacity

Furthermore, we are currently identifying the appropriate Adult Social Care contribution to the following new partnership initiatives that the Leeds system has identified and agreed via the High Impact Change Model process :-

- Frailty Assessment Unit
- Leeds Integrated Discharge Service (Age UK elements)

Leeds City Council has been leading a two year programme to re-procure care home beds for the city which is set to result in the award of new contracts in December 2017. Working with the Leeds CCGs and independent sector care provider representatives, we have recently engaged an independent consultant to conduct a review of provider costs to inform the setting of fees for the new contracts.

Adult Social Care has increased the rates it pays for homecare from June 2017.

The detail of the schemes being supported by the Spring Budget funding are in Appendix 1 these are summarised below:

| Area | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|
| Prevention/Early Intervention | 1,245,754 | 2,022,006 | 2,189,987 |
| Reducing Pressure on the NHS | 2,539,048 | 2,894,302 | 2,179,887 |
| Sustainability of the Care Market | 100,000 | 465,120 | 465,120 |
| Leeds Health and Care Plan | 666,667 | 666,667 | 666,666 |
| **TOTALS** | **4,551,469** | **6,048,095** | **5,501,660** |

Our initiatives for prevention and early intervention for those at risk of or with emerging health and social care needs seek to reduce or delay the need for those people to seek statutory social care and health services:

a) Investment in Strengths Based Social Care Interventions
b) Investment in Asset Based Community Development Approaches
c) Improved Information and Skills Training for people dealing with people with Dementia
d) Investment in Falls Prevention
e) Investment in Carers Support Services
f) Increased capacity in Neighbourhood Networks
g) Investment in a Positive Behaviour Service to reduce the long term costs of care for supporting young people with challenging behaviours

Our initiatives specifically designed to immediately reduce the pressure on the NHS are intended to prevent people presenting and/or speed of discharge back into the community:

a) Increasing the effectiveness of the reablement service
b) Improving Nutrition and Hydration for those over 65
c) Development of community based peer support networks for people with Long Term Conditions
d) Investment in the Community Equipment Service to improve the speed of discharge
e) Investment in Telecare smart rooms to demonstrate the effectiveness of Telecare to aid recovery at home
f) Continuation of the Age UK Hospital to Home Service
g) Additional investment in Social Work support on hospital wards during the winter period
h) Investment in the Social Work Rapid Response Service to reduce admissions and improve DToC's on weekends
i) The development of a frailty assessment unit
j) Implementation of the Trusted Assessor model at both LGI and St James'
k) Additional provision for transitional beds for winter 2017/18
l) Contribution to the development of the YAS Emergency Care Practitioners scheme.

Given the nature of the non-recurrent basis of the Spring Budget funding we have found it difficult to use the funding to directly support the sustainability of the care market, however, as outlined above in relation to our use of the recurrent iBCF we have prioritised ensuring the currency of our fee rates through a cost of care exercise. In addition we have established a Care Quality Team to support Care providers in the city in improving the quality of care provided through advice, support and organisational development opportunities.

## 7. National Conditions

Signatories to the plan (The Health and Wellbeing Board) have been made aware of the timescales for the creation and submission of the plan for the 11th September 2017. Representation from BCF Delivery Group attended the Health and Wellbeing Board on 24th July to confirm the arrangements for the plan, improved better care fund and DFG.

The Leeds Health and Wellbeing Board is made up of:

- ICE/BCF Partnership Board will review and agree the plan prior to submission to the Health and Wellbeing Board
- Sign off from Cllr Charlwood (Chair of Health and Wellbeing Board will sign off the plan.

The overall approach to the investment of the Spring Budget monies and the criteria adopted was endorsed at a special Leeds Health and Well-being Board workshop in April 2017. The Q1 return which preceded this plan was approved by the Leeds BCF Partnership Board.

Supporting Evidence – links and documents to be included:

- Leeds Plan (Leeds Health & Care Plan)
- Leeds Health and Wellbeing Strategy
- Leeds Health and care System Integration in Leeds
- Best Council Plan
- Leeds Housing Strategy
- 'One Voice' - Developing a vision for General Practice in Leeds
- LCC Breakthrough project – Making Leeds the best place to grow old in
- High Impact Change Model
- 16 / 17 spend and draft 17 / 18 Spend predictions

National condition 2: social care maintenance

As part of our preparations for this plan, we have revisited our position in relation to the maintenance of social care. The Leeds health and care system recognises the importance of capacity within social care to enable the efficient and effective operation of the Leeds health economy. With this in mind, we have reviewed the short and medium plans for social care in Leeds and have determined that the level of support required does not require a change to either the baseline for social care support or changes to the allocations within this plan.

However, in 2020/21 it is predicted that adult social care will face a further significant funding gap. This is recognised as a system wide pressure. We will therefore develop a city-wide agreement between statutory organisations (CCG and Local Authority) which will support and aim for the recurrent release of resources currently tied up in unplanned care including non-elective activity across the city. This contribution of freed up resources from a reduction in unplanned care will be prioritised towards the declared funding gap of £2.8m within Social Care. Agreement to this arrangement will be sought from NHSE to ensure that this commitment is fully understood and associated risks recognised irrespective of any other local changes in NHS organisational structures in the future. This will be ratified by CCG Governing Body and LCC Executive Board. We anticipate that this funding will be released from but not be dependent upon reducing non-elective activity through the work of the BCF up to 2020/21.

Partners across Leeds are committed to developing and delivering solutions to the address the three gaps: health and wellbeing, care quality and finance and efficiency, through the Leeds Health and Care Plan. In developing and delivering those plans, partners are committed to developing a system wide solution to enable this contribution to adult social care to be made.

National condition 3: NHS commissioned out-of-hospital services

The BCF will commission out-of-hospital services to the value of £26.3m. Analysed as:

- Mental Health £ 5.8m
- Community Health £17.6m
- Continuing Care £ 0.3m
- Primary Care £ 2.1m
- Other £ 0.5m

Contingency funds for Non-Elective Admissions have been provided at £7.5m.

As stated elsewhere in this document there is a significant investment in Community Beds to provide out of hospital care.

National Condition 4: Managing Transfers of Care

Ensuring smooth flow between hospital and community services is a key priority for the Leeds health and care system. In recent years the level of focus on systems flow has increased. In 2015 Leeds undertook significant work supported by the then Trust Development Agency (TDA) to understand reasons for delays in discharge from hospital and to support the development of a range of projects to improve flow. The outcome of that work focussed efforts in three key areas

a) Improving out of hospital capacity to address capacity gaps
b) Improving coordination of assessment and discharge planning processes within the hospital
c) Improving communications with external agencies to improve coordination of discharge

Over the last two years the Leeds system partners have continued to build on the work undertaken in 2015. This work has included

a) Redesign of reablement services to support early discharge. The new models enables the hospital to discharge patients on a trusted assessor model (see later). Patients will be returned home and seen by the reablement team within 4 hours of discharge.

b) Reprocurement of Community Bed Capacity: The Leeds system has undertaken a redesign and tender exercise for a new model of community bed provision. This new model is due to go live in November 2017 and will support the transfer to assess model. This will enable patient to be discharged to a sub-acute setting whilst their ongoing and future needs are assessed.

To support the work on Transfer of Care the Leeds A&E Board have established a Transfer of Care Group (TOC). Over the past 18 Months the TOC Group have focused on developing and implementing the High Impact Change Model.

The TOC group has overseen the establishment of an Multi-disciplinary Discharge Team. This team known as Leeds Integrated Discharge Service (LIDS) brought together a range of professionals previously managed as separate teams into a cohesive admission avoidance and discharge assessment and planning service. The service brings a range of nursing, Physio and Occupational Therapy and social work under one structure to ensure that assessment and discharge planning processes are seamless and coordinated. The model went live on 19th October 2016 and underpins our approach to many of the high impact changes. The focus to date for the LIDS has been on admission avoidance in A&E and admission assessment wards along with 9 medical admission wards A national model has been developed to support CCGs and LA assess where there are in terms of for development towards delivery of the High Impact Changes and to support planning for future. The model describes 5 levels of attainments

1) Not yet established
2) Plans in place
3) Established
4) Mature
5) Exemplary

The table below summarises our current status with regards to delivering the model

| Change | Current Position |
|---|---|
| Early Discharge Planning | Mature |
| Systems to monitor patient flow | Plans in Place |
| Multi-disciplinary/ multi-agency discharge teams | Partly Established |
| Home first/discharge to assess | Established |
| Seven day services | TBC |
| Trusted Assessors | Partly Established |
| Focus on Choice | Mature |
| Enhancing health in care homes | Established |

Further details on implementation of the 8 high impact changes and future plans are outlined below

**Change 1 Early discharge planning**. All patients admitted as an emergency/ unscheduled care are assessed and an expected date of discharge is be set within 48 hours. Those patients that require supported discharge are referred to the LIDS Team who coordinate multi agency assessments and plan and arrange discharge. Those that will return to usual residence with no additional support are manged by the wards. Further work is required to extend the LIDS approach to all admission wards

**Change 2 Systems to monitor patient flow**. Work is being undertaken by the Leeds Operational Resilience Group to develop capacity and demand systems that will enable a daily assessment of peaks and troughs in system flow across all providers.

This analysis will inform the systems OPEL rating. The daily reporting wil underpin our approach to escalation and mutual aid whereby all providers will develop plans for supporting systems flow in extremis. Work is beginning undertaken to develop electronic mechanisms to capture data

**Change 3 Multi-disciplinary/multi-agency discharge teams**, The Leeds system has established a Multi-agency Team known as LIDS which includes staff from acute community social care and community services along with voluntary and community sector. As stated above the service coordinates discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients. The service currently covers medical wards only. Work is being undertaken to understand the options for extending to all wards

**Change 4 Home first/discharge to assess**. The Local Authority has a range of transitional beds available and has recently implemented changes to the reablement service to support faster discharge. In addition the Leeds Community Beds Service will offer a range of step up and step down 'step-down' beds to bridge the gap between hospital and home meaning that people no longer need wait unnecessarily for assessments in hospital. In addition Leeds have commissioned a Hospital to Home Service from Age UK Leeds which supports the discharge of patients home who need a little short term support to re settle after a temporary acute episode

**Change 5 Seven-day service.** Leeds has a range of seven day service. We are looking at a range of pathways to establish which services should be working seven days may offer the most benefit in terms of improving quality and systems flow. We are implementing a new respiratory service that will work seven days as a first step in understanding these benefits. Respiratory has been chosen due to the evidence that Leeds has very high levels of admissions due to respiratory disease along with delays in discharge especially over weekends. A workshop is being undertaken to further understand priorities for 7 day working.

**Change 6 Trusted assessors**. The Leeds system has implemented trusted assessors for a range of services as part of its Integrated Discharge Service. LIDS Team members are trusted assessors for discharges to reablement, district nursing, community beds and equipment services. Further work is being undertaken to develop trusted assessors for nursing homes. This will include a pilot into the use of telemedicine to support remote assessment of patients by care homes.

**Change 7 Focus on choice**. The LIDS Team are responsible for ensuring a focus on choice. The LIDS Team undertakes a weekly review of all patients that are in the process of choosing a care home. We have a robust escalation process in place to support those patients where delays are beyond that which would be reasonably expected. The LIDS Team includes resource from Age UK Leeds that supports patients to find a care home

**Change 8 Enhancing health in care homes.** Leeds CCGs and the LA have a number of schemes in place to support care homes. Work is currently being undertaken to review provision and identify good practice across the three CCGS with the aim of developing a single model for all care homes. The Leeds health system are looking at

a range of initiatives, including increasing access to IT (telecare) to support care homes in future. We are part of the West Yorkshire Care homes

## 8. Overview of funding contributions

Funding contributions into the BCF have been agreed and confirmed. For 2017/18 these are:

- £51.2m minimum CCG contribution,
- £6.2m Disabled Facilities Grant,
- £16.2m both elements of the improved Better Care funding in line with all directives.

In addition the local Authority has included additional contributions pertinent to two specific schemes (Leeds Community Equipment Service, and South Leeds Independence Centre).

The CCG contribution will be used in part to fund:

- Care Act duties £1.9m
- Reablement £4.5m
- Carer's Breaks £2.1m

## 9. Programme Governance

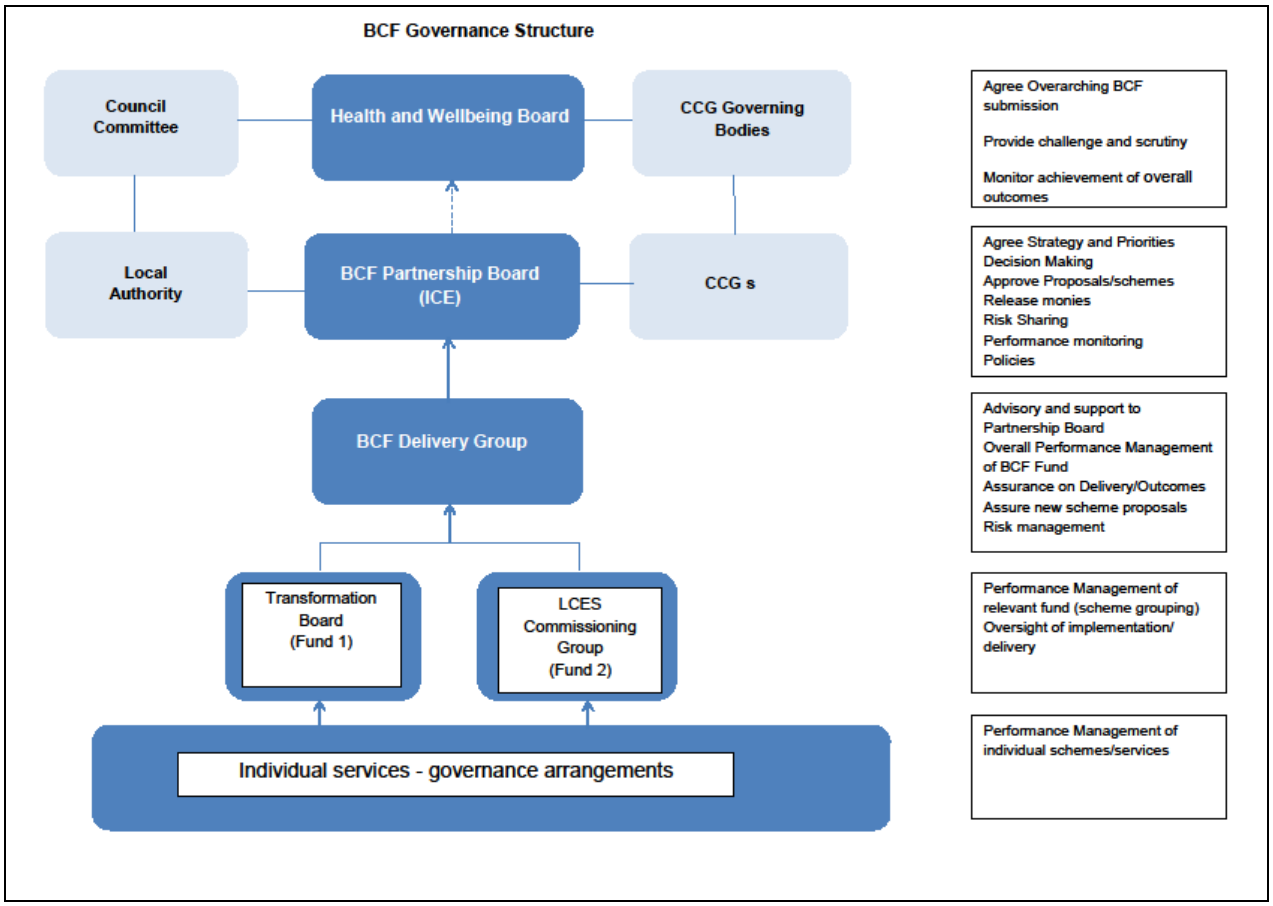
A joint review of the governance arrangements across the health and social care partner organisations during 2016/17 has resulted in the creation of the Leeds Health and Care Partnership Executive Group. Members include the Chief Executive of Leeds City Council, Accountable Officers from the Leeds CCGs, the Chief Executives from health providers, the Directors of Adult Social Services and Children's Services and the Director of Public Health. This reflects the commitment in Leeds to use shared resources – the 'Leeds pound' and represents the next step towards working as one health and care system for the benefit of everyone in Leeds.

The aim of the Leeds Plan is to build on the work of integration that has been undertaken and supported by the BCF, but with a wider and more progressive reach. To help facilitate this, an Integrated Care Delivery Board is to be established for the city of Leeds. Its members will include representation from all three clinical commissioning groups in Leeds, Adult Social Care, Public Health Services and Primary Care.

The BCF will continue to be informed by the Leeds Plan, the Leeds CCGs' operational plans and the local A&E action plan in 2017/19. In particular the BCF will enable the

sustainability of those schemes that will help reduce NEAs, maintain the reductions achieved in respect of Delayed Transfers of Care (DTOCs) and extend the work we have done to integrate health and social care.

The BCF is managed by a robust governance structure with clear reporting lines and accountability processes. The diagram below describes this:




. The BCF Delivery Group is jointly chaired by the accountable officer for the CCG and the responsible chief officer for the Council and is responsible for assurance and overall performance management of delivery of the BCF plan.

There is a methodical performance management process, the Delivery Group receives a scheme tracker and financial information every month and regular evaluation reports for each scheme.

The BCF Partnership Board has been merged into the CCGs' and Council's Integrated Commissioning Executive (ICE), as they have the same membership. The Terms of Reference for ICE are attached as a supporting document, section 4 part 6 being specifically about responsibilities for the BCF. ICE is responsible for agreeing strategies and priorities and making decisions on spend within the BCF. BCF is a standing agenda item at ICE monthly meetings.

The risk sharing agreement as part of the BCF Terms of Reference (provided with the 2016/17 BCF Plan) remains in place and will be reviewed to ensure its consistency with this Plan.

## 10. Assessment of Risk and Risk Management

As can be seen from the Governance arrangements, risk management of the BCF Plan is addressed at multiple levels, with risk being monitored and reviewed, as appropriate by:

- Integrated Commissioning Executive
- System Resilience Assurance Board
- A&E Plan Board
- LTHT Executive Board
- BCF Partnership Board and
- BCF Delivery Group

Any new schemes are supported by a business case which has to be signed off by the Partnership Group following assurance at the Delivery Group level.

The current risk log for the Delivery Group is below:

| **Risk** | **Likelihood** *(scale of 1-5 with 1 being very unlikely and 5 being very likely)* | **Potential impact** *scale of 1-5 with 1 being a small impact and 5 being a major impact* | **Overall risk factor** *(likelihood *potential impact)* | **Mitigating Actions** |
|---|---|---|---|---|
| Funding streams are not long enough to allow delivery of the initiatives and mainstreaming of successful schemes | 3 | 4 | 12 | • Active performance management of Schemes to be undertaken by the BCF Delivery Group<br>• Review of schemes/initiatives prior to year2 of the plan to rebalance if required.<br>• CCGs to monitor to assess budget impact for year3 onwards.<br>• Owner: BCF Delivery Group |
| Workforce issues – recruitment and retention of staff, has a negative impact on delivery of services | 5 | 5 | 25 | • Workstream within the Leeds Plan<br>• Monitored by BCF Delivery Group?<br>• Subject to frequent review<br>•<br>Owner: Accountable officers and BCF Partnership Board. |

| | | | | |
|---|---|---|---|---|
| Growth in demand for services over and above that expected and planned for | 2 | 5 | 10 | • Schemes monitored by the BCF Delivery Group<br>• Review of schemes/initiatives prior to year2 of the plan to rebalance if required.<br>Owner: System Resilience group |
| Schemes geared towards reducing Non Elective Admissions do not have the level of impact that is expected | 2 | 4 | 8 | • Schemes monitored by the BCF Delivery group.<br>• Appropriate action will be taken to address any schemes not meeting targets.<br><br>Owner: Accountable officers and BCF Partnership Board. |
| Failure to achieve NEA targets | 3 | 4 | 12 | • CCGs are confident in the target, based on local demographics<br>• The BCF Plan looks to address NEAs<br>• Close monitoring of the target by the System Resilience Group<br>• The financial contingency that has been identified and set aside.<br><br>Owner: Accountable officers, BCF Partnership Board and LTHT executive board |
| Meeting the DTOC target | 2 | 3 | 6 | • DTOC Plan and strategy for sustained improvement<br><br>Owner: System Resilience group |
| Mainstreaming schemes into the wider transformation programme | 2 | 3 | 6 | • Schemes not funded by BCF in 2016/17 have been placed on the CCG operational planning process for 2016/17<br><br>Owner: Integrated Commissioning Executive |
| Use of the Leeds £ could have an adverse impact on provider stability and/or | 3 | 3 | 9 | • Close monitoring of the effect of schemes and initiatives on the Provider market.<br>o engagement in scheme delivery<br>o provider stabilitity<br>o system capacity & capability<br><br>Owner :BCF Partnership Board |
| Workforce resilience in the face of a pandemic/crisis | 4 | 2 | 8 | • Each partner has their own business continuity plan in place<br>• Subject to frequent review<br>• Escalation paths in place.<br><br>• Owner: Accountable officers and BCF Partnership Board. |

## 11. National Metrics

The CCGs have submitted operational plans that assume a growth in NEA of 2.4%. This is in line with national expectation on growth. The CCG plans do not include anticipated impact of the BCF schemes as they are based on historic growth as was required by NHS England as part of planning process

There are a number of initiatives planned that may reduce activity growth below that expected e.g. increased admission avoidance through frailty unit.

As stated earlier in this document Leeds Non Elective Activity and historic growth patterns are somewhat hard to measure due to coding changes implemented by our main provider in recent years. We do now believe that the full impact of coding changes should be reflected in 2016/17 activity figures and therefore enable us to compare like with like in the current year.

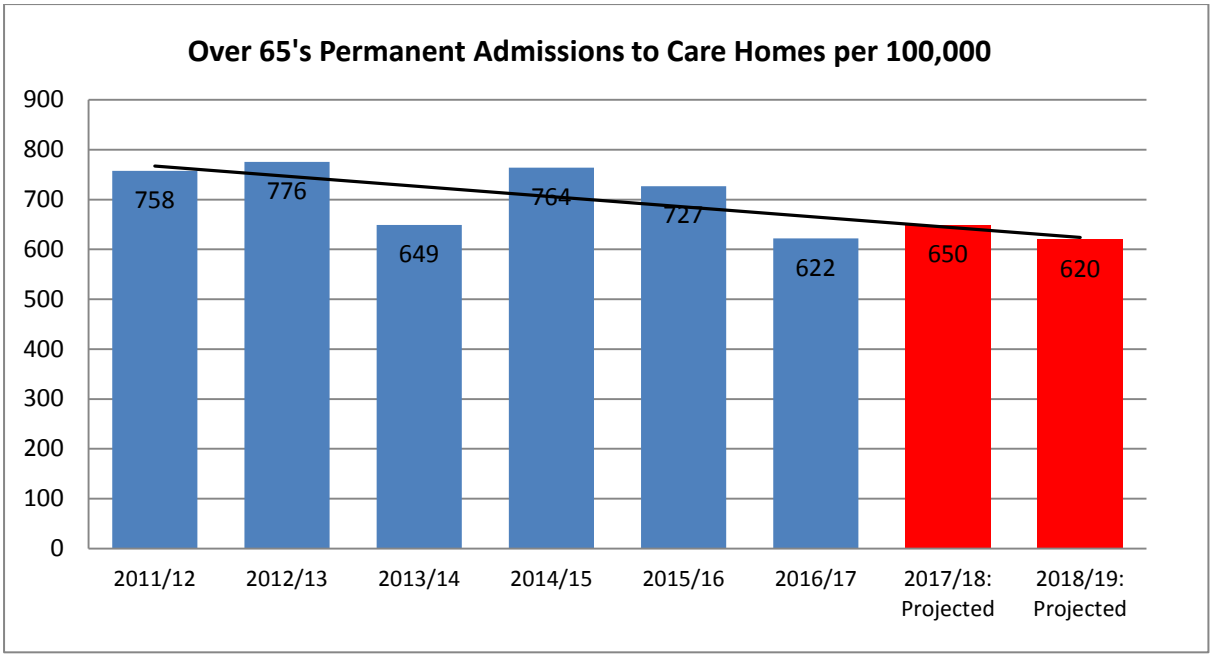
The CCGs financial position is not dependent upon on any further reduction of growth through BCF to achieve a balanced financial position. However The CCGs are holding a contingency against over performance of Non Electives. This contingency (£7million) is included in. the BCF plan.**ASCOF Measure 2A(2): Permanent Care Home Admissions for Over 65's**

The ASCOF measure looks at the number of admissions in relation to the estimated older people population for the LA. As the population estimates are changed each year by the ONS this measure does factor in and reflect estimated demographic changes.

The BCF target for 2016/17 was 750.4 admissions per 100,000 over 65 (910 actual). The outturn was well below this at 622 admissions.

Top quartile performance for 2015/16 was between 513.3 and 188 admissions per 100,000. The all England average was 628 and the comparator average 760.

The following graph includes conservative projections for 2017/18 and 2018/19 based upon recent trends and should the current direction of travel continue and self-funders continue to be excluded.




## Risks and Issues

Projected trends can not anticipate the impact of any specific changes to the current context, for example, the introduction of more Community Beds or increased efforts to free hospital beds.

BCF Contribution to Target Reduction

The Community Beds scheme is expected to have a direct impact and reduce the above figure due to its focus on recovery, reablement and the aim of returning people to their own homes. The transfer to assess pathways is intended to allow people greater recuperation outside a hospital setting and both encourage and build confidence that will allow people to retun to their own homes.

As documented in Section 5, the Leeds strategy is to maximise the independence of its citizens through a preventative strength-based approach to social care and linking people to the existing assets in their own communities. One intended outcome of this strategy is that the demand for care home placements will be levelled by maximising the time that people can be supported in the community. The metrics stipulated by DCLG for the iBCF returns are therefore at odds with this. Indeed, we would view a reduction in these metrics as a sign of success. We recognise that these metrics have been selected at a national level based on an assumption that all areas would view the funding of more care packages as the route to improved system flow and, in particular, reduced DTOCs. However, the funding of these packages is not an obstacle to system flow in Leeds and our investment in improving DTOC performance will focus on the agreed priorities identified through the HICM as detailed above. We are pleased therefore that you have recognised local variation such as this by inviting us to use local metrics that better reflect what we aim to achieve in Leeds whilst still

satisfying the purpose and conditions of the grant. We are therefore adopting metrics of:-

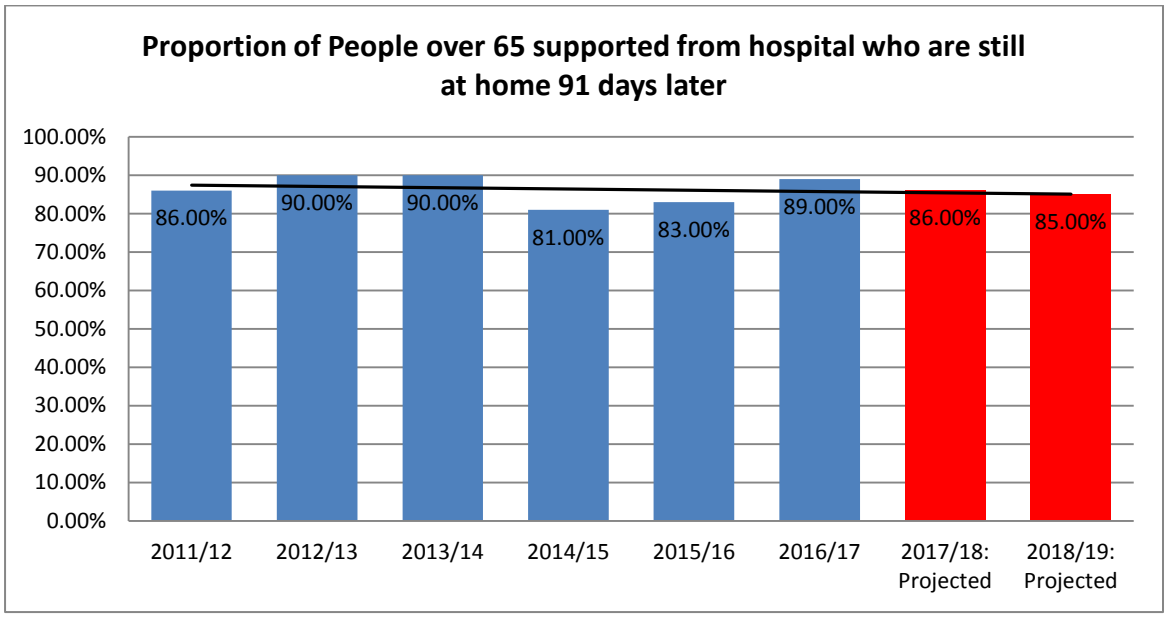
1. number of bed weeks residential/nursing care commissioned (as opposed to the number of placements in residential) and
2. number of home care hours relative to residential (non-nursing) care bed weeks

The target for 1 above is still under development. The target for 2 has been set at 2.91 for 2017/18 (actuals for 15/16 and 16/17 were 1.81 and 1.87 respectively).

ASCOF Measure 2B(1): Reablement – Proportion of people over 65 supported from hospital who are still at home 91 days following discharge

This ASCOF measure includes people who have completed reablement and a check has been undertaken by SKiLs staff 91 days following completion. In addition data is obtained through Caretrak. This includes people with social care involvement leaving hospitals that are further supported through ICT. Caretrak looks for any hospital, residential or other activity up to 91 days after discharge.

The target for the BCF 2016/17 was 92.5%. Top quartile performance for 2015/16 was between 88.6 and 100%. The all England average was 83% as was the comparator average.




## Risks and Issues

It is unclear whether the Caretrak data will be available in future years due to changes in community care including access to datasets and JCM changes. Available data suggests this could have an impact upon the results of up to 8%.

Projected trends can not anticipate the impact of any specific changes to the current context, for example, the introduction of more CC beds or increased efforts to free hospital beds.

The performance target for home care reablement is being reset for 17/18 to reflect the service pathway change implemented at end of Quarter 1. Performance to be monitored through A & H DLT performance report and Budget Action Plan.

BCF Contribution

The BCF target for 2017/19 is 90%, which requires an improvement on the projected trend through the BCF schemes and initiatives.

Again the Community Beds strategy, both in increased bed numbers and new pathways aims to assist with the reablement of people, ensuring that they leave an acute setting as soon as they are able and moving to a Community setting for any necessary period of recovery, rehabilitation and reablement. The Community Beds and other Recovery Hubs can also be used as a step-up service, thus ensuring that any deteriorating conditions are addressed rapidly and before they deteriorate to the stage where acute services are required.

The new service model for home care reablement has been introduced to

1. Improve the speed at which the service picks up customers referred to it.
   Under the previous model, 40% of customers the service accepted never actually started the service. The delays were related to a range of factors, from the person changing their mind about accepting the service, lack of appropriate documentation being provided from the assessor, the person not being fit to leave hospital or the person being admitted to hospital.
   The new model, as described above, includes that the specific assessment and planned out comes for the service are done by the service itself, and the service will now respond to a referral (where appropriate) within four hours.
2. Introduce a full service 7 days a week 8 am to 10pm
   The service can now accept new referrals and respond 7 days a week and extended hours. This includes being able to call on Occupational Therapy support 7 days a week 8am to 8pm from a new Occupational Therapy Recovery Team.

3. Widen the range of reablement interventions
   The support worker role has now been extended to work with customers outside the home as part of their reablement to link them back into community activity or to support them to develop new social contacts.
4. Enable people to leave the service more smoothly at the end.
5. Along with the issue in 1 above that meant 40% of accepted referrals never actually started service, service flow has also been impaired by the slowness of moving customers out of reablement once the service and customer agreed they had reached the maximum benefit.

6. In the new model, where the person does not need any ongoing support funded through an individual care plan, the SkILs service can discharge the person without reference back to care management. They will provide advice and signposting as part of that service. Where the person does need ongoing support, eg long term home care, provided and funded through a care plan, the Social Work Service have committed to pick up that referral in 48 hours. The aim is to get the statement of people's needs (known as an Individual Service Agreement – ISA) to Care Communications Centre as quickly as possible so that an appropriate long term provider can be identified.
7. The new model was introduced with particular reference to joint working with the Leeds Integrated Discharge Service (LIDS) who have been agreed as Trusted Assessors to refer directly to the service. The joint working and relationships between SkILs and LIDS has been a very positive aspect of the introduction of the new model and is enabling us, we all think, to have a real impact on flow out of LTHT.

The Leeds Health and Care Systems have reviewed and agreed a trajectory that will result of over 25% of bed days associated with DTOCS. This equates to a reduction of an average of 83 to 59 DTOCs per day. This will be achieved through a reduction of 13 DTOCs that are waiting for a response from Health services and 11 per day related to social care/local authority.

We have undertaken an analysis of the DTOCs to understand the reasons for delays across all providers that admit Leeds patients. The table outlines the provider breakdown of the Leeds Delays

| Organisation | Leeds Total | Split | |
|---|---|---|---|
| | | LA | Health |
| LTHT | 59 | 8 | 51 |
| LYPF | 11 | 10 | 1 |
| Others | 13 | 6 | 7 |
| **Total Average Winter** | **83** | **24** | **59** |
| **Targets** | **59** | **13** | **46** |
| | | | |
| **Reductions** | **24** | **11** | **13** |

The table above shows that 70% of the Leeds DTOCs are in Leeds Teaching Hospital (LTHT). Our analysis of the DTOCS in LTHT indicate that on average of the 59, 51 will be attributable to health and 8 will be attributable to LA.. This suggests that whilst health will need to focus largely on LTHT to reduce its DTOCs the LA will need to place a greater emphasis on other providers. This creates a significant challenge as it will

require work on a number of fronts. The table below outlines delays in LTHT as % in each category

| Category | National | Leeds |
|---|---|---|
| Awaiting Completion of Assessment | 18% | 17% |
| Awaiting further non acute NHS Care | 18% | 12% |
| Awaiting Care Home Package | 17% | 4% |
| Awaiting Nursing Home Placement or availability | 13% | 3% |
| Awaiting Residential Home Placement or availability | 11% | 0% |
| Patient or Family Choice | 12% | 50% |
| Awaiting Public Funding | 4% | 2% |
| Housing | 3% | 4% |
| Awaiting Community Equipment or Adaptions | 2% | 6% |
| Disputes | 1% | 2% |
| * If we include Mental Health as all Non Choice overall % in Choice would be 43% | | |
| * Improving Choice wouldn't contribute to LA targets | | |

For health the key focus will be on LTHT with a focus on the following

a) Through the use of increased capacity in the Integrated Discharge Service to eliminate delays associated with assessment

b) Increasing flow into transfer assess beds (new CIC service) to reduce number of patients waiting for NHS non Acute Care

c) Improving processes to reduce time patients are taking to choose care homes. This will include enhancing support to patients through use of Age UK to act as 'estate agent' for patient when choosing homes along with increasing focus on working with patients and families to ensure minimum stays for those patients who are struggling to secure a placement in their preferred home.

d) Consideration of improving capacity for hard to place patients that are suffering from dementia and as such are being refused placements by care homes

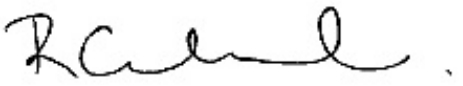
For Adult Social Care the focus will be wider including

a) Increased Hospital Social Work capacity at LTHT to minimise assessment delays
b) Increasing use of re-ablement and transfer to assess beds to reduce delays for patients waiting in an acute hospital bed for home care package or care home placement. These patients will now be managed in sub-acute settings
c) Review of approach to delays in Mental Health Trust. This may include improving time taken to place patients for dementia care and into supported housing.

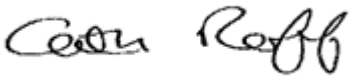
d) Review of delays in Harrogate and Mid Yorks to reduce overall time taken to support discharge. This may include increased use of discharge to assess capacity

## 12. Approval and sign off

Provide confirmation of who has signed up to the BCF plan
Provide the date of Health and Wellbeing agreement (for the second submission of plan)

| | |
|---|---|
| **Signed on behalf of the Health and Wellbeing Board** | Leeds Health and Wellbeing Board |
| **By** |  Cllr Charlwood |
| **Position** | Chair of Health and Wellbeing Board |
| **Date** | 11 September 2017 |

| | |
|---|---|
| **Signed on behalf of the Clinical Commissioning Groups** | Leeds South and East CCG |
| **By** |  Philomena Corrigan |
| **Position** | Chief Executive |
| **Date** | 11 September 2017 |

| | |
|---|---|
| **Signed on behalf of the Council** | Leeds City Council |
| **By:** |  Cath Roff |
| **Position** | Director of Adults and Health |
| **Date** | 11 September 2017 |

**Reference documents**

- Leeds Health and Wellbeing Strategy
- West Yorkshire Sustainability and Transformation Plan
- Leeds Housing Strategy 2016 - 2021
- Leeds Market Position Statement 2015-18 (revised June 2017)
- A3 Version of the Leeds Health and Care Plan on a Page
- Draft Leeds Health and Care Plan
- Delivering the forward view: NHS Planning guidance 2016 - 2021

**Appendices: Supporting Documents**

- Appendix 1a: Schemes supported by BCF Monies (Any new or amended schemes are highlighted in yellow)
- Appendix 1b: Schemes supported by iBCF Monies
- Appendix 1c: Integrated Commissioning Executive (ICE) Terms of Reference

**Appendix 1a**

## 2017/18 Better Care Fund (starting position)

| Pooled Fund | Scheme | Services | Total Value £ | Partnership Contributions | | | |
|---|---|---|---|---|---|---|---|
| | | | | South & East | West | North | Leeds City Council |
| Fund 1: CCG Hosted Services | Mental Health (Leeds North CCG) | Advocacy stat | 142,000 | 52,838 | 55,479 | 33,682 | 0 |
| | | Alzheimers | 112,000 | 41,675 | 43,758 | 26,566 | 0 |
| | | Community Links | 2,582,459 | 960,933 | 1,008,967 | 612,559 | 0 |
| | | Dementia Advocacy support | 57,296 | 21,320 | 22,386 | 13,591 | 0 |
| | | Dementia post | 36,240 | 13,485 | 14,159 | 8,596 | 0 |
| | | Leeds Involving people | 49,344 | 18,361 | 19,279 | 11,704 | 0 |
| | | Leeds Mind befriending | 30,000 | 11,163 | 11,721 | 7,116 | 0 |
| | | Leeds Mind employment service | 626,000 | 232,935 | 244,578 | 148,487 | 0 |
| | | Leeds survivor led crisis service | 257,382 | 95,772 | 100,559 | 61,051 | 0 |
| | | Making space | 79,000 | 29,396 | 30,865 | 18,739 | 0 |
| | | MH carers (LPFT) | 72,000 | 26,791 | 28,130 | 17,078 | 0 |
| | | Touchstone | 262,795 | 97,786 | 102,674 | 62,335 | 0 |
| | | **Scheme Subtotal** | **4,306,516** | | | | |
| | CCG Community & Third Sector Services | CHC respite | 278,126 | 103,296 | 98,039 | 76,791 | 0 |
| | | Community Matrons (LCH) | 2,600,000 | 935,480 | 1,046,500 | 618,020 | 0 |
| | | Geriatricians (additional) (LCH) | 195,000 | 70,161 | 78,488 | 46,352 | 0 |
| | | HALP (LCH) | 182,661 | 65,721 | 73,521 | 43,419 | 0 |
| | | HALP Primary Care (Bevan Healthcare) | 57,339 | 20631 | 23079 | 13629 | 0 |
| | | LD Respite | 1,300,000 | 483,730 | 507,910 | 308,360 | 0 |
| | | Leeds bereavement care (CRUSE) | 58,000 | 21,582 | 22,661 | 13,758 | 0 |
| | | Leeds bereavement forum | 39,000 | 14,512 | 15,237 | 9,251 | 0 |
| | | Leeds Society for Deaf & Blind | 70,000 | 25,186 | 28,175 | 16,639 | 0 |
| | | Stroke Association | 76,000 | 27,345 | 30,590 | 18,065 | 0 |
| | | William Merritt | 172,000 | 61,886 | 69,230 | 40,884 | 0 |
| | | Balance from DIAL Decommissoning | 22,478 | 8,088 | 9,047 | 5,343 | 0 |
| | | Previous Balance (minus Carers Bereavement & ECLO) | 13,380 | 4,814 | 5,385 | 3,180 | 0 |
| | | **Scheme Subtotal** | **5,063,984** | | | | |
| | Community Beds | Bed Bureau (LCH) | 50,000 | 17,990 | 20,125 | 11,885 | 0 |
| | | CIC beds(excluding Reablement) | 2,689,285 | 967,605 | 1082437 | 639,243 | 0 |
| | | CIC beds Medical cover | 126,170 | 45,396 | 50,783 | 29,991 | 0 |
| | | 12 CIC beds | 470,000 | 169,106 | 189,175 | 111,719 | 0 |
| | | ICT therapies support for 12 beds (LCH) | 180,000 | 64,764 | 72,450 | 42,786 | 0 |
| | | Reablement-Richmond House | 632,000 | 227,394 | 254,380 | 150,226 | 0 |
| | | V Ward/CICU (LCH) | 2,000,000 | 719,600 | 805,000 | 475,400 | 0 |
| | | **Scheme Subtotal** | **6,147,455** | | | | |
| | Enhancing Primary Care Services | Various | 2,141,204 | 734,127 | 881,731 | 525,345 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Admission Avoidance - Marginal Tariff/NEL** | Various | 2,800,000 | 1,007,440 | 1,127,000 | 665,560 | 0 |
| | **Information Technology** | Various | 467,050 | 168,045 | 187,988 | 111,018 | 0 |
| | | **Fund 1 Total Value:** | **£20,926,209** | | | | |

| **Pooled Fund** | **Scheme** | **Services** | **Total Value £** | **Partnership Contributions** | | | |
|---|---|---|---|---|---|---|---|
| | | | | **South & East** | **West** | **North** | **Leeds City Council** |
| **Fund 2: Council Hosted Services** | **South Leeds Independence Centre** | SLIC | 2,070,715 | 514,771 | 575,863 | 340,081 | 640,000 |
| | | SLIC pharmacy | 10,500 | 3,778 | 4,226 | 2,496 | 0 |
| | | SLIC Medical cover | 145,000 | 52,171 | 58,363 | 34,467 | 0 |
| | | **Scheme Subtotal** | **2,226,215** | | | | |
| | **Leeds Community Equipment Service** | LCES (minus CHC Equipment) | 4,385,541 | 676,978 | 757,320 | 447,243 | 2,504,000 |
| | | Continuing Healthcare Equipment (shift to fund 1?) | 632,000 | 227,394 | 254,380 | 150,226 | |
| | | **Scheme Subtotal** | **5,017,541** | | | | |
| | **ASC Community & Third Sector Services** | Advocacy consortia | 37,492 | 13,490 | 15,091 | 8,912 | 0 |
| | | Age UK Leeds (formerly Age Concern in fund 1) | 20,000 | 7,196 | 8,050 | 4,754 | 0 |
| | | Carer's Home respite | 98,210 | 35,336 | 39,530 | 23,345 | 0 |
| | | Carers respite breaks | 100,000 | 35,980 | 40,250 | 23,770 | 0 |
| | | Carers support | 115,626 | 41,602 | 46,539 | 27,484 | 0 |
| | | Carers - Bereaved Carers Project | 39,774 | 14,311 | 16,009 | 9,454 | |
| | | DIAL (17/18 Non-recurrent only) | 15,000 | 5,397 | 6,038 | 3,566 | 0 |
| | | Forum Central (formerly LOPF and Volition) | 85,582 | 31,461 | 33,806 | 20,315 | |
| | | Reablement | 2,807,000 | 1,009,959 | 1,129,818 | 667,224 | 0 |
| | | Sensory Impairment Support (ECLO from Fund 1 Balance) | 17,352 | 6,243 | 6,984 | 4,125 | |
| | | **Scheme Subtotal** | **3,336,036** | | | | |
| | **Central Allocations** | NHS England 11/12 Leeds City Council allocation Care bill | 14,466,000 | 4,652,265 | 5,851,498 | 3,962,237 | 0 |
| | **Disabilities facilities grant** | Various | 5,630,909 | | 0 | 0 | 5,630,909 |
| | | **Fund 2 Total Value:** | **£30,676,701** | | | | |
| | | **Contingency fund** | **7,500,000** | 2,475,317 | 3,193,750 | 1,830,933 | 0 |
| | | **Total BCF Value 2016-17** | **59,102,910** | (includes LCC contributions) | | | |

**Appendix 1b**

# SUPPORTED

| Reference | Proposal (summary) | Intended Impact | Requested by | 2017/18 | 2018/19 | 2019/20 | Total |
|---|---|---|---|---|---|---|---|
| • | **Prevention/early intervention** | | | £ | £ | £ | £ |
| SB2 | Further testing of Asset Based Community Development (ABCD) | Prevention/Self Care/Self Management - OP | Mick Ward | 55,000 | 115,000 | - | 170,000 |
| SB7 | Sustain the CCG/Time to Shine funded 'Supporting Wellbeing and Independence for those living with Frailty service | Prevention/Self Care/Self Management - OP | Lucy Jackson | 60,000 | 60,000 | 60,000 | 180,000 |
| SB8 | Customer Access -To fully adopt strength based social care | Prevention/Self Care/Self Management - All | David Hargreaves /Anne McMaster | 42,792 | 42,792 | - | 85,584 |
| SB12 | Development of use of Local Area Coordination (LAC) support | Prevention/Self Care/Self Management -LD | Shona McFarlane | 90,000 | 258,000 | 258,000 | 606,000 |
| SB13 | Dementia: information & skills (online information & training) | Prevention/Self Care/Self Management -OP/D | Tim Sanders | 40,000 | 70,000 | 155,000 | 265,000 |
| SB14 | Embed Falls Prevention Programme - Make if Fall proof and PSI | Prevention/Self Care/Self Management - OP | Lucy Jackson | 130,000 | 130,000 | 130,000 | 390,000 |
| SB15 | Time for Carers - increase the funding of grant | Carer Capacity - ALL | Ian Brooke-Mawson | 75,000 | 75,000 | 75,000 | 225,000 |
| SB17 | Working Carers - expand existing and on-going work at Carers 'Leeds Working Carers Project' | Carer Capacity - ALL | Ian Brooke-Mawson | 25,000 | 25,000 | 25,000 | 75,000 |
| SB22 | Better Conversations for Health and well being a training programme and culture change across Leeds | Prevention/Self Care/Self Management - All | Lucy Jackson | 100,000 | 100,000 | 100,000 | 300,000 |
| SB26 | To ensure the sustainability of social care Lunch Club provision from 2018/19 | Prevention/Self Care/Self Management - OP | Lucy Jackson /Richard Porter | - | 166,500 | 166,500 | 333,000 |
| SB28 | Green Gym (TCV) -links mental and physical health which has become a priority for the city as it is highlighted in the 5 Year Forward View for Mental Health | Prevention/Self Care/Self Management - MH | Sinead Cregan | 142,879 | 181,854 | 167,359 | 492,092 |
| SB30 | Increase capacity of Neighbourhood Networks | Prevention/Self Care/Self Management - OP | Mick Ward | - | 282,000 | 564,000 | 846,000 |
| SB34 | Ideas that Change Lives (ITCL) Investment fund | Prevention/Self Care/Self Management - All | Mick Ward | 25,000 | 25,000 | - | 50,000 |
| SB37 | To create volunteer driver posts at Assisted Living Leeds to collect small items of equipment | Prevention/Self Care/Self Management - OP | Katie Cunningham | 25,000 | 10,000 | 5,000 | 40,000 |
| SB39 | Learning resource in recovery hubs (dementia/MH) | Prevention/Self Care/Self Management - OP/D | Katie Cunningham /Dianne Colley | 80,000 | 20,000 | 20,000 | 120,000 |
| SB41 | To create a 2 year fixed term post of Business Development Manager for Assistive Technology. | Prevention/Self Care/Self Management - OP | Liz Ward | 28,692 | 54,885 | 54,885 | 138,462 |
| SB44 | Positive Behaviour service | Prevention/Self Care/Self Management - LD | Janet Wright | 250,000 | 250,000 | 250,000 | 750,000 |
| SB61 | Falls (LCH) | Prevention/Self Care/Self Management -OP | Megan Rowlands | 76,391 | 155,975 | 159,243 | 391,609 |
| • | **Reducing pressure on the NHS** | | | 1,245,754 | 2,022,006 | 2,189,987 | 5,457,747 |
| SB3 | To increase flow through SkILS reablement service | DToC/Return within 91 days - OP | Liz Ward /Julie Bootle | 140,406 | 270,812 | 270,812 | 682,030 |

| Reference | Proposal (summary) | Intended Impact | Requested by | 2017/18 | 2018/19 | 2019/20 | Total |
|---|---|---|---|---|---|---|---|
| SB21 | To establish the 'Leeds Malnutrition Prevention Programme' targeted at those over age 65. | NEA/LoS/DToC | Richard Porter | - | 51,000 | - | 51,000 |
| SB24 | To ensure the sustainability of the Health Partnerships Team after 2018/19 | Integration & Partnership Working | Lynne Hellewell | - | 153,900 | 153,900 | 307,800 |
| SB25 | Development of sustainabl peer support networks for people with long term conditions | Prevention/Self Care/Self Management - OP (Health) | Lucy Jackson | 70,000 | 70,000 | 70,000 | 210,000 |
| SB31 | Equipment service | DToC - OP | Liz Ward | 410,000 | 350,000 | 350,000 | 1,110,000 |
| SB36 | Telecare Room package for the recovery bed bases (CAPITAL?) | DToC/Return within 91 days - OP | Katie Cunningham | 195,000 | - | - | 195,000 |
| SB49 | Yorkshire Ambulance Service Practioners scheme | | Phil Corrigan | 250,000 | 250,000 | 250,000 | 750,000 |
| SB50 | Frailty Assessment Unit | | Debra Taylor Tate | 350,000 | 350,000 | 350,000 | 1,050,000 |
| SB52 | Hospital to Home Service | DToC - OP | John Tatton | 420,000 | 210,000 | 105,000 | 735,000 |
| SB54 | Staffing resilience for addressing key Health pressure points | DToC - OP | Julie Bootle | 109,437 | 109,437 | 109,437 | 328,311 |
| SB55 | Business Support to facilitate smoother and quicker discharge | DToC - OP | Julie Bootle | 54,171 | 54,171 | 54,171 | 162,513 |
| SB58 | Respiratory Virtual Ward | DToC - OP | Allison Gummerson | 273,467 | 558,415 | - | 831,882 |
| SB66 | Rapid Response | NEA/DToC | Julie Bootle | 66,567 | 66,567 | 66,567 | 199,701 |
| SB64 | Trusted Assessor (lgi) | | Sajid Azeb | 100,000 | 200,000 | 200,000 | 500,000 |
| SB65 | Trusted Assessor (sjuh) | | Sajid Azeb | 100,000 | 200,000 | 200,000 | 500,000 |
| | • **Sustainability of the care market** | | | 2,539,048 | 2,894,302 | 2,179,887 | 7,613,237 |
| SB23 | To ensure the sustainability of alcohol and drug social care provision after 2018/19 | Prevention/Self Care/Self Management - D&A | Lynne Hellewell | - | 365,120 | 365,120 | 730,240 |
| SB35 | A&H - Change Capacity | Efficient Business Processes (incl. payments) | Steve Hume | 100,000 | 100,000 | 100,000 | 300,000 |
| | | | | 100,000 | 465,120 | 465,120 | 1,030,240 |
| | • **Leeds Health and Care Plan** | | | 666,667 | 666,667 | 666,666 | 2,000,000 |
| | | | **TOTAL** | 4,551,469 | 6,048,095 | 5,501,660 | 16,101,224 |
| | | | **Slippage/reinvestment** | | | | - 2,601,224 |
| | | | | | | **Amount available for schemes** | 13,500,000 |

**Appendix 1c**

# Leeds Health and Care Integrated Commissioning Executive (ICE)

## Terms of Reference

**Version: V1.0 | August 2017**

## 1.0 Name

**Full name**: Leeds Health and Care Integrated Commissioning Executive
**Accepted abbreviations**: ICE

## 2.0 Context

The **Leeds Health & Wellbeing Strategy 2016-2021** aims to make Leeds a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest. That's why, as leaders of statutory organisations across the city, we have come together to create a sustainable, high quality health and social care system.

We want to ensure that services in Leeds can continue to provide high quality support that meets or exceeds the expectations of children, young people and adults across the city; the patients and carers of today and tomorrow.

We know that we will only meet the needs of individuals and our population if health and social care workers and their organisations work together in partnership.

We understand that the needs of patients and citizens are changing; the way in which people want to receive care is changing, and that people expect more flexible approaches that fit in with their lives and families.

Front line staff, leaders and managers across organisations are coming together in many ways. We are working closely with the voluntary, faith and charitable organisations, universities and investors to act as one; as if we were a virtual 'single organisation' to improve the health and wellbeing of the people who live or use services in Leeds.

To do this, the Chief Executives and Accountable Officers of the statutory health and care organisations based within Leeds, have agreed to work together in four ways:

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

We know that through working together and seeking out opportunities to integrate our commissioning we will help to accomplish our individual organisational and collective goals and deliver greater outcomes for the people of Leeds. The NHS Five Year Forward View has suggested a sustainable strategy should address three clear areas of improvement on which to focus our efforts:

- **The health and wellbeing gap:** if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

- **The care and quality gap**: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- **The funding and efficiency gap**: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

The **Leeds Health and Care Plan** applies this in a plan for all ages that will:

- Protect the vulnerable and reduce inequalities
- Improve quality and inconsistency
- Build a sustainable system within the reduced resources available

ICE will be cognoscente of the need for integrated provision and to this end when considering decisions will ensure our hospitals, community health and care service providers, GPs, local authority and commissioning organisations will work with citizens, elected members, volunteer, community and faith sector and our workforce to design solutions bottom up that will

- Change the conversation around health and care and have citizens at the centre of all decisions
- Build on the strengths in ourselves, our families and our community; working with people, actively listening to what matters most to people, with a focus on what's strong rather than what's wrong
- Invest more in prevention and early intervention, targeting those areas that will make the greatest impact for citizens
- Use neighbourhoods as a starting point to further integrate our health, social care and volunteer, community and faith sector around GP practices providing care closer to home and a rapid response in times of crisis
- Takes a holistic approach working with people to improve their physical, mental and social outcomes in everything we do
- Use the strength of our hospital in specialist care to support the sustainability of services for citizens of Leeds and wider across West Yorkshire

When working together in partnership, we have agreed a set of principles to help guide our behaviours and values.

| Principles of our approach | | |
|---|---|---|
| **We put people first:**<br>We work with people, instead of doing things to them or for them, maximising the assets, strengths and skills of Leeds citizens and our workforce. | **We deliver:**<br>We prioritise actions over words to further enhance Leeds' track record of delivering positive innovation in local public services. Every action focuses on what difference we will make to improving outcomes and quality and making best use of the Leeds £. | **We are team Leeds:**<br>We work as if we are one organisation, taking collective responsibility for and never undermining what is agreed. Difficult issues are put on the table, with a high support, high challenge attitude to personal and organisational relationships. |

All of this will help to ensure that we contributing to achieving the five outcomes set out in the Leeds Health and Wellbeing Strategy 2016-2021:

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

Progress will be measured at citywide level, and individual organisations will develop any necessary indicators to make sure we are all playing our part.

## 3.0 Assumptions

The four statutory delivery organisations that make up ICE will be efficient and effective within their own 'boundaries' by reducing waste and duplication generally.

All partners will collaborate more effectively on infrastructure and support services

ICE will support the Leeds Health and Care Plan to turn the 'demand curve' through:

- Investment in prevention activities, focusing on those that provide the biggest return and in the parts of the city that will have greatest impact
- Ensuring that throughout we work with our citizens and workforce (not doing things to them or for them), transferring some activities currently undertaken by employees in the statutory sector to individuals, and maximising the use of community assets;
- Reducing waste and duplication in cross-organisational pathways;
- Ensuring that the skill-mix of staff appropriately and efficiently matches need.

ICE will consider recommendations on which services offer least value in terms of outcomes to the Leeds £.

## 4.0 Specific functions undertaken by the group

ICE will explore and negotiate opportunities for commissioning of health and social care services in Leeds in a more joined-up manner. This will enable a regular dialogue between the NHS Leeds CCG health commissioners, Leeds City Council social care commissioners and the third sector to enable effective collaboration and decision making which is subject to individual governance arrangements for the NHS Leeds CCGs and Leeds City Council. This will improve health and care services and the health and wellbeing of children, young people, adults and communities in Leeds.

Furthermore, by enabling integration and unblocking system-wide barriers to integration, ICE will ensure the implementation of the Leeds Health and Wellbeing Board's long term strategy for the city and co-ordinate the partnership's commissioning actions to achieve the priorities in the Leeds Health and Wellbeing Strategy 2016-2021.

## 1. Supporting the delivery of the Leeds Health & Wellbeing Strategy

- Using the 5 outcomes and 12 priorities within the Strategy to set the direction and focus of discussions, giving a strategic steer to any financial and governance discussions around the integration of commissioning.
- Ensure that ICE supports to the work of the Leeds Health and Wellbeing Board and the Leeds Health and Care Partnership Executive Group (PEG).

## 2. Integrated Commissioning Strategy

- Develop and have oversight of an Integrated Commissioning Strategy and collective commissioning integrated resources with a holistic approach of its implications and decision making across the whole health and social care system.
- Set system priorities for shared challenges.
- Maximise the impact of 'Leeds assets' and the value of every 'Leeds Pound' spent on improving health and social care for the population in the context of reducing resources across the health and social care system and where appropriate achieve this by jointly exploring re-prioritisation of resources across the system.
- Make specific proposals for integrated commissioning of services between health, social care, children's services and public health, using pooled or aligned budgets in line with the Health and Social Care Act 2012.
- Support the health and care system by considering commissioning decisions which will help to establish a population based approach to commissioning and provision of outcomes for an initial, accelerator population segment whilst simultaneously continuing to deliver priority pathways as part of on-going Leeds Health and Care Plan work.
- Assess, shape and respond to the commissioning landscape at a local and regional level.
- Identify opportunities for collaborative and integrated commissioning.
- Identify and develop opportunities for shared posts.
- Identify opportunities for greater efficiency and effectiveness of commissioning and promote a holistic approach to commissioning processes.
- Share and discussing the commissioning plans of all partners.
- Monitor and manage the performance of jointly commissioned work.
- Ensure proposals have had active engagement with patients, service users and the third sector through appropriate standing groups to inform process and reflect the service user's and carer voice's and experience into the planning, delivery and evaluation of health and social care services.

## 3. Commissioning Delivery

- Identify innovative approaches to resource allocation and proposing new approaches of delivery.
- Identify and develop opportunities to integrate the commissioning workforce.
- Discuss effective and efficient use of commissioning support functions.
- Measuring the impact and implications of commissioning decisions for the health and care system and tracking and receiving assurances that delivery has occurred.

## 4. Payments and Incentives

- Design and test a framework for system wide commissioning.
- This involves consideration of new contractual models to incentivise outcomes we want.

### 5. Innovation and Enterprise

- Liaise with academic research and innovation (through Academic Health Partnership) where appropriate to ensure mutual coordination and system support for commissioning strategy in relation to the appraisal and consideration of pilots, and review of high-profile bids for grant funding that bring innovation and resources into Leeds.
- Share the learning from the Leeds health and social care system and draw on innovation at a regional, national and international level.
- Identify how Leeds can use its unique health and care infrastructure and joint strategies to unblock any issues around integrated commissioning.

### 6. Better Care Fund (BCF)

- Oversee the BCF partnership agreement between the NHS Leeds CCGs and Leeds City Council and to monitor the BCF including reviewing the operation of the partnership agreement and risks sharing arrangements.
- Act as a forum for reviewing and considering plans and proposals for BCF funding and promoting the agenda on integration.
- Make recommendations to the Leeds Health and Wellbeing Board in terms of the strategic planning for the Better Care Fund.
- Review quarterly and annual returns, which will be submitted to the Leeds Health and Wellbeing Board and circulated to NHS Leeds CCGs and Leeds City Council Executive Board as appropriate.
- Provide strategic direction, approve, monitor the implementation and performance of individual schemes/services on an exception basis.
- Approve the terms of reference of the BCF Delivery Group as a sub group of ICE, which will provide advice and support to ICE in relation to BCF.

## 4.0 Budget

Currently a budget is not allocated to support the operations of the group and any work is done in kind by partners.

## 4.1 Considerations for the future

Proposals are being developed for a citywide team to support the work of the partnership. Following these recommendations, consideration will be given for a specific budget to be allocated by partners on a fair shares basis to support this group.

## 5.0 Membership

ICE will be jointly chaired by the NHS Leeds CCG Chief Executive Officer and the Director of Adult and Health.

A key feature of the ICE is that the role of members is not to represent the needs of their host organisations, but to represent the best interests of the people of Leeds, thinking city first, organisation second.

## 5.1 Core Membership

Core membership will consist of:

| Organisation | Role |
|---|---|
| NHS Leeds CCGs Partnership | Chief Executive Officer **(Co-Chair of ICE)** |
| NHS Leeds CCGs Partnership | Chief Officer for System Integration |
| NHS Leeds CCGs Partnership | Clinical Chair |
| NHS Leeds CCGs Partnership | Clinical Chair |
| NHS Leeds CCGs Partnership | Director of Commissioning |
| NHS Leeds CCGs Partnership | Director of Finance |
| NHS Leeds CCGs Partnership | Deputy Director of Commissioning (Community Services) |
| Leeds City Council | Director of Adults and Health **(Co-Chair of ICE)** |
| Leeds City Council | Director of Children & Families |
| Leeds City Council | Chief Officer Partnerships, Children & Families |
| Leeds City Council | Director of Public Health |
| NHS Leeds CCGs Partnership and Leeds City Council | Deputy Director, Integrated Commissioning, Adults and Health and NHS Leeds CCGs |
| Yorkshire and the Humber, NHS England | Director of Commissioning Operations |

## 5.2 In attendance where appropriate

| Organisation | Role |
|---|---|
| City-wide | Chief Officer Health Partnerships |
| City-wide | Executive Lead for Lead Health and Care Plan |
| City-wide | Finance Lead for Leeds Health and Care Plan |
| Leeds City Council | Chief Officer Resources and Strategy, Adults and Health |

## 5.3 Substitutes

All members will prioritise attendance at each meeting. Each of the key statutory commissioning functions within the city are represented by at least two representatives at ICE which in effect are acting as substitutes for each other.

Members should not be absent from two consecutive ICE meetings or not be present at less than 9 formal meetings in any 12 month period unless there are exceptional circumstances.

## 5.4 Special advisors

The group may request special advisors to be present for specific agenda items. These may include those representing specific commissioning functions, enabling groups, advising on policy, providing communications support etc.

Requests for special advisors to be in attendance are to be made via the Health Partnerships Team who administers the group.

## 6.0 Governance

## 6.1 Decision making, Voting and Quoracy

### 6.1.1 Decision making

The group draws together senior officers from the partnership and all decisions made within the group are through the authority delegated to individual members of the group from their host partner organisation and conducts its business in the spirit of partnership. Each partner retains its own statutory functions and responsibilities.

The group will provide reports to various host organisation bodies on an issues/exception basis, with no formal reporting timetable in place.

It is the responsibility of ICE's members to obtain appropriate approval within their own organisations (if required) for any decision taken at ICE.

### 6.1.2 Voting & Quoracy

The group will be expected to reach a consensus when agreeing matters of business. This will mean that members are expected to compromise and demonstrate the behaviours listed within the Terms of References.

Quorum for the group will be at least 50% of core members present which must include:

- Two members from Leeds City Council
- Two members from the NHS Leeds CCGs

At the discretion of the chair, where a decision/vote impacts an organisation whose representative member is not present at the meeting a nominated representative will seek agreement outside of the meeting or the decision/vote is deferred to a future meeting.

## 6.2 Relationship with other Boards/Groups

The ICE will provide reports to various host organisation bodies and partnership boards/groups on an issues/exception basis, with no formal reporting timetable in place. It will have a close working relationship with a number of key bodies including:

- Leeds Health and Wellbeing Board
- Children & Families Trust Board (CFTB)
- Children's Joint Commissioning Group (sub group of ICE and CFTB)
- BCF Delivery Group (sub group of ICE)
- Leeds Health and Care Partnership Executive Group (PEG)
- Clinical Senate
- System Resilience Assurance Board (SRAB)
- Accountable Care Development Board
- Population Health Management Group
- Leeds Academic Health Partnership (LAHP)
- Joint Adult Community Commissioning Group
- LD Board (including Transforming Care Programme)
- Mental Health Partnership
- Dementia Board

- Leeds Plan Delivery Group
- Leeds Health Commissioning and System Integration Board
- LCC Corporate Strategic Commissioning Group
- LCC Executive Board

It is anticipated that the above named boards and groups will continue to drive innovation and service change through wider partnership engagement including service providers. ICE will make recommendations for investment and disinvestment across the partnership based on the work and strategies of the related bodies.

### 6.3 Considerations for the future

As the group develops, consideration will be given to more formal governance/decision making models for example, Committee in Common.

## 7.0 Meetings

### 7.1 Frequency

Group will aim to formally meet at least once a month. There may be occasions where this is not possible however, as much notice as possible will be given to any changes in dates/times.

Additional meetings may be arranged if required.

### 7.2 Duration

Each formal meeting is expected to last 3 hours, promptly starting at 14:00 where possible. This will consist of a focus on strategic commissioning related items between 14:00-16:00 and Better Care Fund specific related items between 16:00-17:00 where appropriate.

Meetings may be extended in duration if appropriate at the discretion of the Chairs.

### 7.3 Bringing items

A forward plan for the group will be developed by the group supported by the Health Partnerships Team. This will be reviewed and updated in each meeting.

Additional items can be proposed by Core Members. In addition, a referral can be made from the Leeds Health and Wellbeing Board or the Leeds Health and Care Partnership Executive Group.

A request should be made to the Health Partnerships Team who will collate items into a draft agenda which will be discussed and agreed with the Chairs.

The following information must be provided for any items requested:

1. Title for the item
2. Primary group sponsor for the item
3. Author(s) for the item
4. Reason for coming to the group and expected outcome
5. Estimation of minimum amount of time required for the item

6. Which group meeting the item is requested to come to and an assessment of the criticality of the item coming (i.e. this will assist with determining which items must be on the agenda for a specific meeting if there are too many items).

## 7.4 Structure of meetings

All formal meetings will have an agenda.

Items will be accompanied with a supporting paper and as a minimum an item cover sheet will be completed for any items that require a decision/agreement by the group.

The following items will be standard on all formal agenda meetings:

- Welcome
- Apologies
- Declaration of any conflicts of interest with any of the items that are being discussed as part of the agenda will be raised and noted
- Update on actions from previous meetings
- Additional items as per agenda
- Hot Topics
- Review of forward plan

## 8.0 Standards

## 8.1 Declarations of interest

All group members must complete a declaration of interests form.

Declarations of interest may be published and reviewed as a standing item on all meeting agendas. Attendees who have any direct/indirect financial or personal interest in a specific agenda item will declare their interest. The Chairs of the meeting will decide the course of action required, which may include exclusion from participation in the discussion.

All declarations of interest and actions taken in mitigation will be recorded in the minutes.

## 8.2 Behaviours and practice all members will demonstrate

- Act across the Leeds health and care system in line with Nolan's Seven Principles of Public Life: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership.
- Act in the best interests of the population of Leeds with a commitment to ensuring everything the group does is outcome based, evidence informed and patient/service user informed.
- Resolve differences between members and present a united front in the best interests of the people of Leeds.
- Openness and transparency in discussions.
- Actively work to remove barriers that prevent team working.
- Hold each other to account.
- Be clear in language used to reduce any confusion between group members.

- Seek clarity from other group members if unsure of terminology/language used.
- Offer constructive challenge to improve service delivery and ensure financial balance.
- Openness and transparency in decision making, being explicit of when not agreeing/supporting a decision.
- Stick to decisions that are made at the group.
- Follow through on actions agreed at the group.
- Meet deadlines agreed at the group.
- Prioritise group meetings and core members will aim to attend the full meeting.
- Read all papers in advance of the meeting and come prepared.
- Undertake the necessary discussions within their own organisations prior to the group meeting in order to make decisions within the meeting.

## 8.3 Equality

The group shall have due regard to equality in all its activities, and shall take steps to demonstrate it has consulted with communities appropriately in its decisions.

## 8.4 Transparency and communication of discussions and decision taken

Where appropriate the group shall produce a summary of key messages. These will then be circulated to appropriate boards/groups.

## 9.0 Secretariat support

The secretariat support will be provided by the Health Partnerships Team under direction of the Health Partnerships Programme Manager. This will include:

1. Being a central point of contact for the group
2. Drafting and preparing the agenda
3. Issuing the call for agenda items
4. Formulating formal paper calls on behalf of the group
5. Liaising with authors/leads to ensure that papers meet the requirements of the group
6. Ensuring group meetings are minuted
7. Maintaining an action log for the group
8. Formally requesting officers to undertake specific actions on behalf of the group
9. Advising the group as required on policy
10. Identifying and organising organisational development (OD) for the group
11. Developing a programme of work / forward plan to support the group
12. Acting as a critical friend to group to ensure that group is operating and delivering its outcomes and against the ToRs

Additionally, secretariat support can be delegated by the Chairs to undertake any other activity as deemed appropriate under authority of the group to ensure that the group fulfils its objectives and function.

## 10.0 Date of next review

These Terms of Reference will be reviewed at approximately every 6 months. Date of next review March 2018.