Leeds Health and Wellbeing Board

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Report of: Steve Hume (Chief Officer Resources & Strategy, Adults & Health, Leeds City Council) & Sue Robins (Director of Operations & Delivery, Leeds CCGs Partnership)

Report to: Leeds Health and Wellbeing Board

Date: 19th February 2018

Subject: iBCF (Spring Budget) Q3 2017/18 Return and BCF Performance Monitoring Q3 2017/18 Return

Are specific geographical areas affected? If relevant, name(s) of area(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, access to information procedure rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The Leeds iBCF Spring Budget return for Quarter 3 of 2017/18 (Appendix 1) and the Leeds HWB BCF Performance Monitoring return (Appendix 2) for the same period were submitted to the Department for Communities and Local Government (DCLG) and NHS England (NHSE) respectively by the deadline of 19th January 2018. The quarterly returns were reviewed and approved by the Leeds Health and Wellbeing Board members via email and this paper is provided to the Health & Wellbeing Board (HWB) for information.

The DCLG requires Local Authorities to submit quarterly returns regarding their use of the 'Spring Budget' adult social care element of local Better Care Funds (BCF).

NHSE requires HWB areas to complete and submit the BCF performance monitoring quarterly return to ensure the requirements of the BCF are met and enable areas to provide insight on health and social integration.

The iBCF Spring Budget returns are distinct from the BCF performance monitoring quarterly returns however, the deadlines for both these returns have now been synchronised.

The completion and submission of the iBCF Spring Budget quarterly return allows central government to monitor the success of the BCF/iBCF/Spring Monies and to provide insight on health and social integration.

This report and the relevant returns indicate that Leeds are complying fully with the national conditions of the BCF and that in relation to performance against the key national performance indicators Leeds is on target to meet those for Non-Elective Admissions and the Rate of Admission to Residential Care, however, Leeds performance on the effectiveness of reablement and Delayed Transfers of Care currently remain below target. The reablement service has recently undergone a significant expansion and there is an expectation that the temporary drop in performance will be rectified for the next quarter. The performance on Delayed Transfers of Care is improving, particularly those delays at LTHT where delays attributable to Social Care are currently below target, and those attributable to the NHS are significantly improved. However, in relation to LYPFT delays progress has been has been more mixed, largely as a result of the previous under-reporting outlined at the last HWB meeting.

The iBCF return details the progress made against the range of ‘Invest to Save Schemes’ which have all now been through a robust review of individual business cases. Most schemes are now in the mobilisation stages.

Recommendations

The Leeds Health and Wellbeing Board is asked to:

- Note the contents of this report,
- Note the contents of the Leeds iBCF Quarter 3 2017/18 return to the DCLG, and;
- Note the content of the Leeds HWB BCF Performance Monitoring return to NHSE for quarter 3 of 2017/18.

1 Purpose of this report

1.1 To inform the HWB of the contents of the national iBCF return and the Leeds HWB BCF Performance Monitoring return for 2017/18 Quarter 3.

2 Background information

2.1 The national grant conditions for iBCF Spring Budget funding are:

- Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

- A recipient local authority must:
  a) Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption;
  b) Work with the relevant clinical commissioning group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19;
  c) Provide quarterly reports as required by the Secretary of State.

2.2 In Leeds, we have used this non-recurrent three year funding to fund transformational initiatives that have compelling business cases to support the future management of service demand and system flow and prevent and delay the need for more specialist and expensive forms of care.

This is founded on the principles of the Leeds Health and Care Plan, which sits under the Leeds Health & Wellbeing Strategy) and links to the West Yorkshire & Harrogate Health and Care Plan.

Each bid is supported by a robust business case which will address the challenges faced around health and wellbeing, care quality and finance and efficiency. A robust approach has been established which will:

- Measure the actual impact of each individual initiative
- Monitor actual spend on each initiative and release funding accordingly
- Ensure that appropriate steps are being taken to identify ongoing recurrent funding streams after the iBCF funding period ends in cases where initiatives prove to be successful
- Ensure that exit strategies are in place for initiatives that do not achieve their intended results

3 Main issues

iBCF (Spring Budget) 2017/18 Quarter 3 Return

3.1 The return details twenty of the thirty-six iBCF initiatives that are being funded. Only twenty schemes are covered in detail on the return because, according to the DCLG, the spread-sheet is not designed for such a large number of projects. On

the advice of DCLG it was decided to only include detail on the top twenty schemes with the highest overall investment. These are:

Falls Prevention
Neighbourhood Networks
Leeds Community Equipment Services
Local Area Coordination (LAC)
Transitional Beds
Better Conversations
Lunch Clubs
The Conservation Volunteers (TCV HOLLYBUSH) - Green Gym
Positive Behaviour Service
Falls Pathway Enhancement (LCH)
SkILs Reablement Service
Health Partnerships team
Yorkshire Ambulance Service Practitioners scheme
Frailty Assessment Unit
Hospital to Home
Staffing resilience
Respiratory Virtual Ward
Trusted Assessor (LGI)
Trusted Assessor (SJH)
Alcohol and drug social care provision after 2018/19

3.2 The remaining sixteen schemes are included in a full list provided in the narrative. These are:

Dementia: Information & skills (online information & training)
Time for Carers
Working Carers
Asset Based Community Development (ABCD)
Prevent Malnutrition Programme
Peer Support Networks
Ideas that Change Lives (ITCL) investment fund
A&H - Change Capacity
Telecare Smartoom
Assisted Living Leeds Volunteer Drivers
Learning & Information Resource in recovery hubs

Business Development Manager for Assistive Technology post
Business Support for Discharge Process
Rapid Response
Supporting Wellbeing and Independence for Frailty (SWIFt)
Customer Access

3.3 The majority of the individual schemes are at the early stages of development as can be seen in the progress comments for the twenty schemes. This is due to the review of schemes by a cross-partner Panel held on 7th December 2017 prior to release of funds.

The purpose of the Panel was to ensure there was confidence that each bid was supported by a robust business case which addressed the challenges we face (health and wellbeing, care quality and finance and efficiency). The cross-partner nature of the panel was intended to bring a different system perspective and constructive challenge to ensure that collectively there was a balanced and holistic evaluation.

The Panel was considered very successful and all members agreed it was a useful process which would promote better conversations in the future, ensuring that as a partnership we are in the best position to deliver the right outcomes for the citizens of Leeds.

3.4 In response to the questions in the return we calculate that the additional Spring Budget funding has the potential to fund 11,000 additional home care packages (126,000 hours) and an extra 219 care home placements. However, it should be noted that Leeds has the continued aim of reducing care home bed weeks by better meeting people's needs within their own homes and communities.

3.5 This strategic direction is reflected by the two locally devised metrics for measuring the impact of the Spring Budget monies that we have proposed in the return:

- Number of commissioned care home weeks (65+);
- Percentage of new client referrals for specialist social care which were resolved at point of contact or through accessing universal services.

3.6 Additional metrics, yet to be agreed, based on the schemes are being considered for inclusion in the Quarter 4 return.

BCF Performance Monitoring Return Quarter 3 Return for 2017/18

3.7 The Quarter 3 BCF Performance Monitoring Return indicate that Leeds are complying fully with the national conditions of the BCF and that in relation to performance against the key national performance indicators Leeds is on target to meet those for Non-Elective Admissions and the Rate of Admission to Residential Care, however Leeds performance on the effectiveness of reablement and Delayed Transfers of Care currently remain below target. The reablement service has recently undergone a significant expansion and there is an expectation that the temporary drop in performance will be rectified for the next quarter. The

performance on Delayed Transfers of Care is improving, particularly those delays at LTHT where delays attributable to Social Care are currently below target, and those attributable to the NHS are significantly improved. However in relation to LYPFT delays progress has been has been more mixed, largely as a result of the previous under-reporting outlined at the last HWB meeting.

4 Health and Wellbeing Board governance

4.1 Consultation, engagement and hearing citizen voice

4.1.1 Routine monitoring of the delivery of the BCF is undertaken by a BCF Delivery Group with representation from commissioners across the city. This group reports in to the BCF Partnership Board, which in turn reports to the Leeds Health and Wellbeing Board in relation to the BCF. The BCF Plans in Leeds have been developed based on the findings of consultation and engagement exercises undertaken by partner organisations when developing their own organisational plans.

Any specific changes undertaken by any of the schemes will be subject to agreed statutory organisational consultation and engagement processes.

4.2 Equality and diversity / cohesion and integration

4.2.1 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. The vision that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest' underpins the Leeds Health and Wellbeing Strategy 2016- 2021. The services funded by the BCF contribute to the delivery of this vision.

4.3 Resources and value for money

4.3.1 The Spring Budget iBCF is focussed on initiatives that have the potential to defer or reduce future service demand. As such the funding is being used as 'invest to save'.

4.4 Legal Implications, access to information and Call In

4.4.1 There are no access to information and Call In implications arising from this report.

4.5 Risk management

4.5.1 There is a risk that some of the individual funded initiatives do not achieve their predicted benefits. This risk is being mitigated by ongoing monitoring of the impact of the individual schemes and the requirement to produce exit/mainstreaming plans for the end of the Spring Budget funding period.

5 Conclusions

5.1 Adults & Health will continue to submit quarterly returns to DCLG regarding the use and impact of Spring Budget monies as required under the grant conditions.

5.2 Locally we will continue to monitor the impact of the schemes and plan towards the exit from the Spring Budget funding period.

6 Recommendations

6.1 The Leeds Health and Wellbeing Board is asked to:

- Note the contents of this report,
- Note the contents of the Leeds iBCF Quarter 3 2017/18 return to the DCLG, and;
- Note the content of the Leeds HWB BCF Performance Monitoring return to NHSE for Quarter 3 of 2017/18.

7 Background documents

7.1 None.

How does this help reduce health inequalities in Leeds?
The BCF is a programme, of which the iBCF is a part, spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

How does this help create a high quality health and care system?
The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.

How does this help to have a financially sustainable health and care system? The iBCF Spring Budget monies have been jointly agreed between LCC and NHS partners in Leeds and is focussed on transformative initiatives that will manage future demand for services.

Future challenges or opportunities
The initiatives funded through the iBCF Spring Budget monies have the potential to improves services and deliver savings. To sustain services in the longer term, successful initiatives will need to identify mainstream recurrent funding to continue beyond the non-recurrent testing stage.

Priorities of the Leeds Health and Wellbeing Strategy 2016-21	
A Child Friendly City and the best start in life	
An Age Friendly City where people age well	X
Strong, engaged and well-connected communities	X
Housing and the environment enable all people of Leeds to be healthy	
A strong economy with quality, local jobs	
Get more people, more physically active, more often	
Maximise the benefits of information and technology	
A stronger focus on prevention	X
Support self-care, with more people managing their own conditions	X
Promote mental and physical health equally	X
A valued, well trained and supported workforce	
The best care, in the right place, at the right time	X

QUARTERLY REPORTING FROM LOCAL AUTHORITIES TO DCLG IN RELATION TO THE IMPROVED BETTER CARE FUND

Section A

A1. Provide a narrative summary for Quarter 3 which follows up the information you have provided in Section A in previous returns. What are the key successes experienced? What are the challenges encountered?

Please note: per advice from DCLG only the top 20 schemes (in terms of overall investment) have been included on the return). The full list of the schemes is:

Asset Based Community Development (ABCD); SkILs Reablement Service; Supporting Wellbeing and Independence for Frailty (SWIFt); Customer Access; Local Area Coordination (LAC); Dementia: Information & skills (online information & training); Falls Prevention; Time for Carers; Working Carers; Prevent Malnutrition Programme; Better Conversations; Alcohol and drug social care provision after 2018/19; Health Partnerships team; Peer Support Networks; Lunch Clubs; The Conservation Volunteers (TCV HOLLYBUSH) - Green Gym; Neighbourhood Networks; Leeds Community Equipment Services; Ideas that Change Lives (ITCL) investment fund; A&H - Change Capacity; Telecare Smartoom; Assisted Living Leeds Volunteer Drivers; Learning & Information Resource in recovery hubs; Business Development Manager for Assistive Technology post; Positive Behaviour Service; Yorkshire Ambulance Service Practioners scheme; Frailty Assessment Unit; Hospital to Home; Staffing resilience; Business Support for Discharge Process; Respiratory Virtual Ward; Falls Pathway Enhancement (LCH); Transitional Beds; Trusted Assessor (LGI); Trusted Assessor (SJH); Rapid Response

In addition, the following schemes are no longer included in the top 20:
Capacity for transition to strengths-based approaches; Retaining care home capacity during service transformation

Since Q2, Leeds has:

1. Further mobilised a broad transformational programme across Care and Health services funded through the Spring Budget monies
2. Continued to use the spring budget money to reverse planned service reductions that would have otherwise been inevitable (as detailed in our Q1 return to DCLG)

The transformational programme is focussed on initiatives that have compelling business cases to support the future management of service demand and system flow and prevent and delay the need for more specialist and expensive forms of care. This is

founded on the principles of the Leeds Health and Care Plan as described in the narrative of Leeds Better Care Fund Plan (which sits under the Leeds Health & Well-Being Strategy and links to the West Yorkshire & Harrogate Health and Care Plan (STP).

We have prioritised funding for schemes that support our preparations for winter for example: SB49 – Yorkshire Ambulance Service practitioner scheme; SB50 – Frailty Assessment Unit; SB52 – Hospital to home; SB64 & SB65 – Trusted assessors.
Since Q2, a monitoring/accountability structure has been established which:-

- Measures the actual impact of each individual initiative
- Monitors actual spend on each initiative and releases funding accordingly
- Ensures that appropriate steps are being taken to identify ongoing recurrent funding streams after the iBCF funding period ends in cases where initiatives prove to be successful
- Ensures that exit strategies are in place for following the lifetime of the Spring Money funding or if the initiatives that do not achieve their intended results and are ceased.

This programme of initiatives was developed through discussions between the Leeds City Council, the Leeds CCGs Partnership and the local NHS provider trusts and has been locally formally agreed by sign off from the Leeds Better Care Fund Partnership Board. A joint panel of local authority and NHS commissioners and providers convened in December 2017 to ensure that all proposals satisfied the requirements set out above.

The aim of the panel was to bring different system perspectives and constructive challenge to ensure that collectively there was a balanced and holistic assessment of the proposals. It was also an opportunity for Scheme Leads to provide sufficient confidence to the Panel that their schemes are appropriately developed in a number of key aspects, in particular, realisation of benefits.

As part of the follow up to the panel Scheme Leads have been made aware, by letter, of their responsibilities to provide the following on an ongoing basis:

- Submission of the required information on scheme spending and benefit delivery for the quarterly iBCF return to DCLG and NHSE, including the impact (if any) on key national metrics in a timely manner;
- Progress reports on delivery of the scheme and its benefits, including the escalation of issues that are likely to impact upon the success of the scheme, key gateways/milestones reached;
- Any requirements identified by the Leeds Health and Wellbeing Board, via the Leeds Plan Delivery Group to enable it to assess the success or otherwise of the scheme during its lifetime.

They were also reminded that all schemes were expected to be clear on the deliverable benefits (including baseline and targets), milestones and exit strategy. If the scheme did not meet these then ongoing funding would be at risk.

A number of the Leeds iBCF initiatives are specifically aimed at improving system flow by:-

1. Managing demand more appropriately at the 'front door' of the hospital (e.g. Frailty Assessment Unit) and
2. Supporting more timely discharge from hospital (e.g. Trusted Assessors)

In this way, the iBCF is supporting the High Impact Change Model delivery for the city.
The iBCF funding is also being used to support Adult Social Care's mandate 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. The Leeds initiatives are therefore founded on these values:-

- 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

As already outlined in the Leeds Quarter 1 and Quarter 2 iBCF returns, the mandated metrics relating to increasing home care and care packages are at odds with our local ambition. Indeed, we seek to reduce or at least level demand for this statutory provision through our strengths-based approach and through prevention, including that provided by our thriving third sector. Our revised local metrics for IBCF funding reflect this:-

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

Metrics remain unchanged from Q2.

During Q4 we will be reviewing and adding local metrics which we will be using to monitor overall success of the programme.

This Q3 return has been approved by the Leeds BCF Partnership Board.

Appendix 1 - iBCF (Spring Budget) Q3 2017/18 Return

A2. Provide progress updates on the individual initiatives/projects you identified in Section A at Quarters 1 and 2. You can provide information on up to 5 additional initiatives/projects not cited in previous quarters to the right of the boxes below if needed.

	Initiative/ Project 1	Initiative/ Project 2	Initiative/ Project 3	Initiative/ Project 4	Initiative/ Project 5	Initiative/ Project 6	Initiative/ Project 7	Initiative/ Project 8	Initiative/ Project 9	Initiative/ Project 10
A2a. Individual title for each initiative/ project	Falls Prevention (SB14)	Neighbourhood Networks (SB30)	Leeds Community Equipment Services (SB31)	Local Area Coordination (LAC) (SB12)	Transitional Beds (SB63)	Better Conversations (SB22)	Lunch Clubs (SB26)	The Conservation Volunteers (TCV HOLLYBUSH) - Green Gym (SB28)	Positive Behaviour Service (SB44)	Falls Pathway Enhancement (LCH) (SB61)
A2b. Use the drop-down options provided	3. In progress: showing results	1. Planning stage	3. In progress: showing results	1. Planning stage	2. In progress: no results yet	1. Planning stage	2. In progress: no results yet	1. Planning stage	1. Planning stage	2. In progress: no results yet
A2c. You can add some brief commentary on the progress to date if you think this will be helpful (in general no more than 2 to 3 lines).	The schemes have been evaluated internally in the services and significant individual improvement in outcome measures seen.	Start date is anticipated to be 1st Oct 2018	Service commenced spend in Sep 17 this has meant the waiting value for equipment for adults without CHC status £132K rather than £258k it was projected to be.	Apr 18 – specification developed to support the development of embedded Intermediaries with the skill and capacity to support communities and people within those communities		This project would start to draw funds from Apr 18 and end Mar 20	Continues to provide an annual Lunch Club small grants scheme for 2018/19 targeted at older people	Dec 17 Initial funding to underwrite preparation and set up Jan 2018 staff recruited to the 4 posts	Dec17/Jan18 - design team structure; develop Job Descriptions with health colleagues	The LCH Falls scheme will run November 2017 – March 2019; development of accredited Safety Huddles commenced Nov with Safety Huddle coach in post

Appendix 1 - iBCF (Spring Budget) Q3 2017/18 Return

	Initiative/ Project 11	Initiative/ Project 12	Initiative/ Project 13	Initiative/ Project 14	Initiative/ Project 15	Initiative/ Project 16	Initiative/ Project 17	Initiative/ Project 18	Initiative/ Project 19	Initiative/ Project 20
A2a. Individual title for each initiative/ project.	SkILs Reablement Service (SB3)	Health Partnerships team (SB24)	Yorkshire Ambulance Service Practioners scheme (SB49)	Frailty Assessment Unit (SB50)	Hospital to Home (SB52)	Staffing resilience (SB54)	Respiratory Virtual Ward (SB58)	Trusted Assessor (LGI) (SB64)	Trusted Assessor (SJH) (SB65)	Alcohol and drug social care provision after 2018/19 (SB23)
A2b. Use the drop-down options provided	1. Planning stage	2. In progress: no results yet	1. Planning stage	3. In progress: showing results	3. In progress: showing results	1. Planning stage	2. In progress: no results yet	2. In progress: no results yet	2. In progress: no results yet	1. Planning stage
A2c. You can add some brief commentary on the progress to date if you think this will be helpful (in general no more than 2 to 3 lines).	Recruitment of the 5 additional SWAs is underway. Anticipated they would be in post early 2018	Temporary funding will enable a period of time for the Council to identify an alternative ongoing funding source	The mobilisation of the St Georges Urgent Treatment Centre Apr 18	Service commenced Nov 17	The scheme is already up and running as was funded originally as part of a government office initiative. Following a robust evaluation funding was extended by agreement through SRAB	ASAP for 3 agency workers to release capacity to commence dedicated work with BRI, HDG and Pinderfields	The project commenced in Sep 17, steering group established Oct 17, model agreed Dec 17	4WTE additional members to be in place from Dec 2017	Scheme already in place - 4WTE additional members to be in place from Nov 17	This project would start to draw funds from Apr 18

Section B: Information not required at Quarter 3

Section C

	Metric 1	Metric 2
C1a. List of up to 10 metrics you are measuring yourself against. Automatically populated based on information provided in Quarter 2. Please ensure your password is entered correctly in cell C13. Scroll to the right to view all previously entered metrics. You can provide information on up to 5 metrics not cited previously to the right of these boxes if needed.	Number of commissioned care home weeks (65+)	Percentage of new client referrals for specialist social care which were resolved at point of contact or through accessing universal services'
C1b. Use the drop-down options provided or type in one of the following 4 answers to report on any change in each metric since Quarter 2: **1. Improvement** **2. Deterioration** **3. No change** **4. Not yet able to report**	1. Improvement	3. No change
C1c. Provide any additional commentary on the metric above, if you wish.	A range of recent work has led to increased capacity in reablement and step down to home services. This is enabling people greater opportunities to recover and regain independence in the community.	

Better Care Fund Template Q3 2017/18

1. Cover

Version 1

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leeds
Completed by:	Lesley Newlove
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Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Rebecca Charlwood

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0

Better Care Fund Template Q3 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Leeds

Confirmation of National Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q3 2017/18

3. Metrics

Selected Health and Well Being Board: Leeds

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	Whilst activity is lower than our plan for the year the length of stay of those patients admitted is generally longer	NEA is below plan	None
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	An increased focus upon transfering people from hospital may increase demand on services to support people to regain independence and lead to	The projected figures show that we will meet the target. Work is ongoing to increase capacity across the city in the provision of CIC beds to	None
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	This measure relates to the proportion of people who are still at home 91 days after being discharged from hospital	ASC reablement services have been restructured to provide more capacity	None
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	Increases in DTOCS reported within the Leeds Mental Health Provider. This has risen from an average of 12 in Q4 last winter to an average of 35 in recent months	Agreement of a number of initiatives to support flow through iBCF. Implemnation of Community Beds Strategy. Also review of options for provision of out of	None

** Your assessment of progress against the Delayed Transfer of Care target should reflect progress against the monthly trajectory submitted separately on the DToC trajectory template*

Better Care Fund Template Q3 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Leeds

		Maturity assessment				Narrative			
		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Established	Established	Mature	Mature		Size of hospital and challenge of ensuring consistent approach across all admission routes and wards across two sites	Closer working between integrated Discharge Service and Hospital Social Work Teams to improve discharge planning. Ongoing work to improve assessment prior to admission through	None
Chg 2	Systems to monitor patient flow	Plans in place	Plans in place	Established	Established		Ensuring routine/daily flows of demand data to support whole system responses to fluctuations in demand. Agreement to establish DTOC monitoring arrangements to all	Establishment of agreed daily system flow reporting by all NHS providers. Agreed Mutual Aid and Escalation Policy across all NHS Providers.	None
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established	Established	Established	Established		Expansion from current limited service (Operating in A&E, Assessment and Medical and elderly Wards only) to whole hospital	Agreement to funding increased for capacity. Agreement to review current model with aim to commission new whole systems model in readiness for winter 2018/19	None
Chg 4	Home first/discharge to assess	Established	Established	Mature	Mature		Large number of care home providers offering different approaches to trusted assesment and variable response times with regards to assessment within reasonable	Increased capacity within reablement to support this approach. New community bed capacity now in place which embeds Transfer to Assess Protocols	None
Chg 5	Seven-day service	Not yet established	Not yet established	Not yet established	Not yet established		Equipment Services are operating on a 7 day basis and iBCF monies have been prioritised for Rapid Response Social Workers to maintain a 7 day service during this coming winter.	Beginning to review feasibility of changing to 7 day working for services where there is interdependence between health and social care and changes in behaviour required to realise	None
Chg 6	Trusted assessors	Established	Established	Mature	Mature		Further work is required to understand options for Trusted Assessment for readmission to existing care homes. Main challenges associated with Trusted Assessment by Care Homes. We are	Single assessment form agreed for use by all organisations/professionals assessing patients. iBCF have approved funding to support increase in Trusted Assessor capacity. This will extend	None
Chg 7	Focus on choice	Mature	Mature	Mature	Mature	Progress is being made on developing options for the commissioning of dementia care. It is estimated that up to 30 delayed transfers of care are associated with difficulties in providing	Lack of provission for patients with complex needs notably elederly with complex mental health issues associated with dementia	Dementia Board Workshop to progress need for solution to issue associated with difficulties in out of hospital provision fro dementia patients. Proposals to be developed in current	None
Chg 8	Enhancing health in care homes	Established	Established	Mature	Mature		See issue re dementia above	Number of schemes in place in Leeds. A review is being undertaken to align three Leeds CCG funded care home schemes ensuring best practice of each embedded in new scheme to be	None

Hospital Transfer Protocol (or the Red Bag Scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	Red Bag scheme	Established	Established	Established	Established		The red bags are not always sent from the actue setting at the same time as the patient	Care Homes have responded well to this scheme	None

Better Care Fund Template Q3 2017/18

5. Narrative

Selected Health and Wellbeing Board: Leeds

Remaining Characters:	18,487

Progress against local plan for integration of health and social care

As articulated in the Leeds 2017-19 BCF Narrative Plan, the Leeds BCF is a contributor to the delivery of the Leeds Health and Care Plan (which in turn forms a strand of the Leeds Health & Well-being Strategy). The Leeds Plan is founded on the development of a Population Health Management approach for the city and all partners have been involved in a series of workshops which has identified the population segments that will be focussed on initially (frailty and end of life.) The new Frailty Unit has been established at LTHT which operates with resources from across health and social care agencies including 3rd sector. It integrates assessment and discharge planning by utilising the skills of staff from LTHT, LCH, Adult Social Care and 3rd sector. Partners are working together to support the commissioning and development of community provision for patients with dementia. This will require agreement to joint commissioning of both clinical teams and independent sector provision.

Our 13 neighbourhood teams continue to work in partnership with other organisations wrapping care around the patient. Each neighbourhood in Leeds is aligned to a Community Geriatrician and integrated neighbourhood team who work with our primary care teams as part of a wider MDT. These teams are providing a greater focus on preventative care and self-management, reducing hospital admissions. Often teams are required to prioritise their caseload to support system flow and respond to urgent and rapid requests.

Remaining Characters:	18,385

Integration success story highlight over the past quarter

A significant area of success in our plan is in respect of implementing a new Community Bed strategy across Leeds. Contracts were awarded for a new Community Care Beds Service (CCBS) in September 2017 following a procurement process led by the Leeds CCGs Partnership in readiness for Winter. The CCBS mobilised on time and has been operational since 1st November 2017. In the first week, 35 patients were admitted to CCBS beds. Capacity has increased to 227 beds across seven bed bases and will cater for both Intermediate Care and a new Transfer To Assess model. The service has been commissioned to provide personalised, proactive care and reablement and rehabilitation and is supported by local general practitioners to provide enhanced cover to beds, community geriatricians and our 13 neighbourhood teams. Over the Winter, teams are being required to ensure that they prioritise their caseloads to ensure support to system flow and admission avoidance.

The pathway into the Community Bed Care Service is being delivered through an integrated approach between Leeds Teaching Hospitals Trust, Leeds Community Healthcare Trust, the Local Authority and the independent sector. The service will now include capacity for hospital 'discharge to assess' patients as well as people requiring active rehabilitation, so that people's longer term care needs can be assessed outside of the hospital environment and reduce delayed transfers of care. The new Community Care Beds Service is grounded within the established integrated Neighbourhood Teams model to ensure smooth transfer for those who are returning home.