Appendix 2 – Summary of Top 10 iBCF Schemes – Q1 18/19

Scheme No. & name of scheme	SB3 SKiLs Reablement Service
Purpose	To increase system flow of patients by placing Case Officers in LTHT and having dedicated Social Work Assistants to support timely exits from reablement where an ongoing service is required.
Expected Benefits	• Increase the number of appropriate referrals to SKiLs from LTHT and reduce length of stay in hospital • Reduce referrals from LTHT which don't become an active reablement intervention • Reduce number of people in transition from reablement and the length of time people are supported in transition by reablement • Improve staff satisfaction through reduced down time and customers in transition and positive working relationships between LTHT and SKiLs
Q1 2018/19 achievements	• Referral pathway developed for referrals from the frailty unit and A&E to prevent hospital admission • 1 Case Officer recruited • All 5 Wellbeing Workers are in post

Scheme No. & name of scheme	SB12 Local Area Coordination & Asset Based Community Development
Purpose	This scheme has been amalgamated with scheme SB2 Asset Based Community Development. The purpose is to support communities using local area coordination and ABCD principles to respond to the needs of people who have or may be in need of social care support.
Expected Benefits	• Improve quality of life for people with low to moderate learning disabilities able to participate actively in their local community in ways that are supportive of them as individuals • Increase the number of people being supported to move on from funded daytime activities into community support for all or some of their time
Q1 2018/19 achievements	• Community connectors have been recognised, groups are running regularly and community events and groups have taken place led by the community for the community • **BHI (Chapeltown) pathfinder:** o Progress has been made by the Community Builder and several community connectors have been identified o The Community Builder is pro-actively visiting other pathfinder sites to see what she can learn from them • **New Wortley Community Centre (New Wortley)**: o Sky News has visited the community centre to find out about their work • **LS14 Trust (Seacroft):** o A board game is being developed for Seacroft which will be used to initiate discussions about the area o A group of local people are involved in a public art sculpture project and have visited both Leeds Art Gallery and the Hepworth to gain inspiration for the pieces they are making locally o Members of the Community Foundation's 100 Club visited the Trust to find out first-hand what they do o As a result of this the Lord Lieutenant is visiting the Trust in August to find out more about the organisation and Seacroft, which may lead to a royal visit o Two community connectors attended the Kings Fund event to tell their stories. At the event one of the connectors realised she had finally conquered her fear of crowds and was relaxed at an event for the first time in years. • **Outcome Framework:** All pathfinders have started using the outcome framework to measure their impact. They have been asked to share their diary/logs after recording their activity for a couple of months.

Scheme No. & name of scheme	SB22 Better Conversations
Purpose	To train health and care staff to have 'better conversations' with the citizens of Leeds and move the conversation to a 'working with' approach.
Expected Benefits	• Decrease in use of services • Implementing a culture change which supports system integration resulting in an unified approach across health and care partners in Leeds • Minimise the costs of preventable illnesses and dependency, inappropriate admissions and prescribed medications • Improved staff engagement, resilience, motivation, job satisfaction, recruitment and retention
Q1 2018/19 achievements	• Engagement meetings have taken place with all key areas suggested by Leeds Plan Delivery Group for deployment • Initial meetings have taken place with a number of key people in respect of the respiratory pathway and LCP (Seacroft/Crossgates) • Pilot sessions planned • A group of stakeholders from the Better Conversations Programme met the Health and Care Evaluation Service (HACES) on August 24th and carried out a workshop to establish a set of testable programme level outcomes that could be used for evaluation. The workshop was based on the outcomes in the 'Whole City Approach to Working with People' infographic and HACES are now working with the products of the session to develop a proposed set of outcomes that Better Conversations can be evaluated against • OD and Training – model developed and training package to be completed by the end of September

Scheme No. & name of scheme	SB23 Alcohol and drug social care provision after 2018/19
Purpose	To fund front line drug and alcohol services for residential rehabilitation, Leeds Housing Concern and spot purchase in order to meet the needs of patients requiring specialist drug and alcohol services.
Expected Benefits	• Reduce hospital admissions
Q1 2018/19 achievements	• There has been an increase in referrals with 19 people commencing residential rehabilitation at St Anne's and 14 people (who commenced their residential rehabilitation during Q4 2017/18 or Q1 2018/19) successfully completing it during Q1. A number of these people had accessed and successfully completed residential detoxification at St Anne's prior to commencing residential rehabilitation • All 6 clients of the service are maintaining their managed alcohol agreements without any relapses. No unplanned hospital admissions. Two of the six have move-on plans in place to seek alternative accommodation and expect to move on during Q2 • Leeds Adults and health fund adults to go out of area to drug rehabilitation services as Leeds does not have such a facility. There has been a focus on rehab at Forward Leeds in the past month and 20 new referrals have been received

Scheme No. & name of scheme	SB30 Neighbourhood Networks
Purpose	Neighbourhood Network schemes are community based, locally led organisations that enable older people to live independently and proactively participate within their own communities by providing services that reduce social isolation, deliver a range of health and wellbeing activities, provide opportunities for volunteering, act as a 'gateway' to advice/information and other services resulting in a better quality of life for individuals.
Expected Benefits	• Increase the number of older people supported by Neighbourhood Networks • Reduce admissions to hospital of older people • Increase the number of older people receiving hospital discharge support • Increase the number of activities delivered to support health and wellbeing
Q1 2018/19 achievements	• Progress to date has involved finalising the project brief/service level agreement and undertaking a competitive grants process

Scheme No. & name of scheme	SB31 Leeds Community Equipment Services
Purpose	To increase the BCF funding for Leeds Community Equipment Service
Expected Benefits	• Increase the amount of level 1 equipment delivered in 48 hours to support discharges, reablement and avoid admissions to hospital • Increase the amount of level 2 equipment delivered within 14 days • Reduce the number of delayed transfers of care due to equipment • Increase the number of people supported to remain at home
Q1 2018/19 achievements	• 94% of level 1 equipment delivered in 48 hours to support discharges, reablement and help to avoid admissions to hospital • 98.97% of level 2 equipment delivered within 14 days • Position at end Q1 18/19 - 235 people waiting for equipment at value of £217,799

Scheme No. & name of scheme	SB49 Yorkshire Ambulance Service Practitioners scheme
Purpose	To fund two Emergency Care Practitioners to be based at the Urgent Treatment Centre who will provide both navigation services and support to minor illness and minor injuries through clinic sessions.
Expected Benefits	• Reduce the need for transport to hospital for less serious conditions • Improve ambulance response times • Decrease attendances in emergency departments • Reduce waits in emergency departments
Q1 2018/19 achievements	• No achievements seen as yet due to redefining scheme

Scheme No. & name of scheme	SB50 Frailty Assessment Unit
Purpose	To fund a multi-agency frailty service initially in St James' to support a strength based approach to the management of frail people presenting or conveyed to the emergency department and promote the ethos of Home First.
Expected Benefits	• Reduce non-elective admissions for those seen in the unit • Reduce the number of lost bed days associated with delayed transfers of care • Reduce the number of people admitted into long term care
Q1 2018/19 achievements	• Nov 17 - March 18 - 80% of patients attending not admitted • Nov 17 - March 18 - 1,000 lost bed days saved

Scheme No. & name of scheme	SB52 Hospital to Home
Purpose	To fund the Leeds Integrated Discharge Service – a multi-disciplinary team to ensure that where possible admissions into hospital are avoided from A&E and the assessment area. In addition the team works across a number of medical wards to support timely discharge of adult medical patients who have presented to the hospital.
Expected Benefits	• Reduce non-elective admissions • Reduce bed occupancy • Reduce the need for home care (ASC and NHS) • Reduce delayed transfers of care bed days associated with Choice • Improved A&E performance • Reduce the number of cancellations of routine surgery
Q1 2018/19 achievements	• Early to assess but demand is below plan • Difficult to assess specific impact of H2H but stranded patient trend is downward • A&E Performance has improved in recent months

Scheme No. & name of scheme	SB58 Respiratory Virtual Ward
Purpose	To fund a Respiratory Virtual Ward to provide intense respiratory support to a defined cohort of patients in their own home.
Expected Benefits	• Reduce hospital admissions • Reduce length of stay in hospital • Increase the number of people in the community with an enhanced care plan to manage exacerbation • Improve outcomes for individuals and improve confidence to self-manage and remain at home where appropriate
Q1 2018/19 achievements	• Service became operational on 1st June as insufficient staff in place and trained before then. Therefore figures provided are not for a full quarter of service delivery • 8 patients, to end of Q1 supported to stay at home (combination of hospital avoidance and early discharge) • Total of 28 days saved to end of June (though 3 patients remain under care of VRW) • 5 people in the community with an enhanced care plan to manage exacerbation • 2 patients discharged with improved outcomes