Better Care Fund Template Q1 2018/19

Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements for 2017-19 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)

2) To provide information from local areas on challenges, achievements and support needs in progressing integration and the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform delivery improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports are submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the Better Care Support Team (BCST) will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCE) prior to publication.

For 2018-19, reporting on the additional iBCF Grant (from the funding announced in the 2017 Spring Budget) is included in the BCF quarterly reporting as a combined template to streamline the reporting requirements placed on local systems. The BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately. MHCLG aim to publish the additional iBCF information in 2018-19.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC should be referenced against your current provisional trajectory. Further information on DToC trajectories for 2018-19 will be published shortly.
The progress narrative should be reported against this provisional monthly trajectory as part of the HWB’s plan.

This sheet seeks seeks a best estimate of confidence on progress against targets and the related narrative information and it is advised that:

- In making the confidence assessment on progress against targets, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.
- In providing the narrative on Challenges, Achievements and Support need, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this very useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires local areas to implement the High Impact Change Model (HICM) for Managing Transfers of Care. This section of the template captures a self-assessment on the current level of implementation, and anticipated trajectory in future quarters, of each of the eight HICM changes and the red-bag scheme along with the corresponding implementation challenges, achievements and support needs.

The maturity levels utilised on the self assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area

Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement

Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

In line with the intent of the published HICM model self assessment, the self assessment captured via BCF reporting aims to foster local conversations to help identify actions and adjustments to progress implementation, to understand the area's ambition for progress and, to indicate where implementation progress across the eight changes in an area varies too widely which may constrain the extent of benefit derived from the implementation of the model. As this is a self assessment, the approaches adopted may diverge considerably from area to area and therefore the application of this information as a comparative indicator of progress between areas bears considerable limitations.

In making the self-assessment, please ensure that a representative range of stakeholders are involved to offer an assessment that is as near enough as possible to the operational reality of the area. The recommended stakeholders include but are not limited to Better Care Managers, BCF leads from CCGs and LAs, local Trusts, Care Sector Regional Leads, A&E Delivery Board representatives, CHIAs and regional ADASS representatives.

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. The AEDB lens is a more representative operational lens to reflect both health and social systems and where there are wide variations in implementation levels between them, making a conservative judgment is advised. Where there are clear disparities in the stage of implementation within an area, the narrative section should be used to briefly indicate this, and the rationale for the recorded assessment agreed by local partners.

Please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making the HICM self-assessment, which could be useful in informing future design considerations.

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide supporting detail on the features of the initiatives and the actions implemented that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter with any impact observed, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

To better understand the spread and impact of Trusted Assessor schemes, when providing the narrative for "Milestones met during the quarter / Observed impact" please consider including the proportion of care homes within the locality participating in Trusted Assessor schemes. Also, any evaluated impacts noted from active Trusted Assessor schemes (e.g. reduced hospital discharge delays, reduced hospital Length of Stay for patients awaiting care home placements, reduced care home vacancy rates) would be welcome.

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
- 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.
- Where 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.
- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:
https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx
Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

5. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related impact.

6. Additional improved Better Care Fund - Part 1

For 2018-19 the additional iBCF monitoring has been incorporated into the BCF form. The additional iBCF section of this form are on tabs '6. iBCF Part 1' and '7. iBCF Part 2', please fill these sections out if you are responsible for the additional iBCF quarterly monitoring for your organisation, or geographic area.
To reflect this change, and to align with the BCF, data must now be entered on a HWB level.
The iBCF section of the monitoring template covers reporting in relation to the additional iBCF funding announced at spring budget 2017 only.
More specific guidance on individual questions is present on the relevant tabs.

Please find a list of your previous Quarter 4 2017/18 initiatives / projects on tab 'iBCF Q4 1718 Projects'.

Section A: Please ensure that the sum of the percentage figures entered does not exceed 100%. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell.
Section B: Please enter at least one initative / project, but no more than 10. If you are funding more than 10 initiatives / projects, you should list those with the largest size of investment in 2018-19.

7. Additional improved Better Care Fund - Part 2

Section C: The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please could you enter 0 in the appropriate box.
Section D: Please enter at least one metric, but no more than 5.

Better Care Fund Template Q1 2018/19

1. Cover

Version 1.0

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website.
Narrative sections of the reports will not be published. *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- 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:	Nottingham
Completed by:	Petra Davis
E-mail:	petradavis@nhs.net
Contact number:	1158839432
Who signed off the report on behalf of the Health and Wellbeing Board:	Cllr Sam Webster/ Dr Hugh Porter

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'

Please go to the Checklist for further details on incomplete fields - Click for link

	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
6. iBCF Part 1	4
7. iBCF Part 2	0

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | Local Government Association | NHS England

<< Link to Guidance tab

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes
Sheet Complete:		Yes

2. National Conditions & s75 Pooled Budget ^^ Link Back to top

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes
Sheet Complete:		Yes

3. Metrics ^^ Link Back to top

	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToC Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToC Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToC Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToC Support Needs	G14	Yes
Sheet Complete:		Yes

4. High Impact Change Model ^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning Q1 18/19	E12	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19	E13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19	E14	Yes
Chg 4 - Home first/discharge to assess Q1 18/19	E15	Yes
Chg 5 - Seven-day service Q1 18/19	E16	Yes
Chg 6 - Trusted assessors Q1 18/19	E17	Yes
Chg 7 - Focus on choice Q1 18/19	E18	Yes
Chg 8 - Enhancing health in care homes Q1 18/19	E19	Yes
UEC - Red Bag scheme Q1 18/19	E23	Yes
Chg 1 - Early discharge planning Q2 18/19 Plan	F12	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19 Plan	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19 Plan	F14	Yes
Chg 4 - Home first/discharge to assess Q2 18/19 Plan	F15	Yes
Chg 5 - Seven-day service Q2 18/19 Plan	F16	Yes
Chg 6 - Trusted assessors Q2 18/19 Plan	F17	Yes
Chg 7 - Focus on choice Q2 18/19 Plan	F18	Yes
Chg 8 - Enhancing health in care homes Q2 18/19 Plan	F19	Yes
UEC - Red Bag scheme Q2 18/19 Plan	F23	Yes
Chg 1 - Early discharge planning Q3 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q3 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q3 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q3 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q3 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	H12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	H13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	H14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	H15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	H16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	H17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	H18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	H19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	H23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	I14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I17	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I18	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I19	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I23	Yes

Chg 1 - Early discharge planning Challenges	J12	Yes
Chg 2 - Systems to monitor patient flow Challenges	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J14	Yes
Chg 4 - Home first/discharge to assess Challenges	J15	Yes
Chg 5 - Seven-day service Challenges	J16	Yes
Chg 6 - Trusted assessors Challenges	J17	Yes
Chg 7 - Focus on choice Challenges	J18	Yes
Chg 8 - Enhancing health in care homes Challenges	J19	Yes
UEC - Red Bag Scheme Challenges	J23	Yes
Chg 1 - Early discharge planning Additional achievements	K12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K15	Yes
Chg 5 - Seven-day service Additional achievements	K16	Yes
Chg 6 - Trusted assessors Additional achievements	K17	Yes
Chg 7 - Focus on choice Additional achievements	K18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K19	Yes
UEC - Red Bag Scheme Additional achievements	K23	Yes
Chg 1 - Early discharge planning Support needs	L12	Yes
Chg 2 - Systems to monitor patient flow Support needs	L13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L14	Yes
Chg 4 - Home first/discharge to assess Support needs	L15	Yes
Chg 5 - Seven-day service Support needs	L16	Yes
Chg 6 - Trusted assessors Support needs	L17	Yes
Chg 7 - Focus on choice Support needs	L18	Yes
Chg 8 - Enhancing health in care homes Support needs	L19	Yes
UEC - Red Bag Scheme Support needs	L23	Yes

Sheet Complete:	Yes

5. Narrative

^^ Link Back to top

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

6. iBCF Part 1

^^ Link Back to top

	Cell Reference	Checker
A) a) Meeting adult social care needs	D11	Yes
A) b) Reducing pressures on the NHS	E11	Yes
A) c) Ensuring that the local social care provider market is supported	F11	Yes
Initative 1 - B1: Individual title	C18	Yes
Initative 1 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	C19	Yes
Initative 1 - B3: 2017-18 Project names as provided in the 2017-18 returns.	C21	No
Initative 1 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	C22	Yes
Initative 1 - B5: Which of the following categories the initiative / project primarily falls under.	C23	Yes
Initative 1 - B6: If "Other", please specify.	C24	Yes
Initative 1 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	C25	Yes
Initative 1 - B8: Report on progress to date:	C26	Yes
Initative 2 - B1: Individual title	D18	Yes
Initative 2 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	D19	Yes
Initative 2 - B3: 2017-18 Project names as provided in the 2017-18 returns.	D21	No
Initative 2 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	D22	Yes
Initative 2 - B5: Which of the following categories the initiative / project primarily falls under.	D23	Yes
Initative 2 - B6: If "Other", please specify.	D24	Yes
Initative 2 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	D25	Yes
Initative 2 - B8: Report on progress to date:	D26	Yes
Initative 3 - B1: Individual title	E18	Yes
Initative 3 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	E19	Yes
Initative 3 - B3: 2017-18 Project names as provided in the 2017-18 returns.	E21	No
Initative 3 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	E22	Yes
Initative 3 - B5: Which of the following categories the initiative / project primarily falls under.	E23	Yes
Initative 3 - B6: If "Other", please specify.	E24	Yes
Initative 3 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	E25	Yes
Initative 3 - B8: Report on progress to date:	E26	Yes
Initative 4 - B1: Individual title	F18	Yes
Initative 4 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	F19	Yes
Initative 4 - B3: 2017-18 Project names as provided in the 2017-18 returns.	F21	Yes
Initative 4 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	F22	Yes
Initative 4 - B5: Which of the following categories the initiative / project primarily falls under.	F23	Yes
Initative 4 - B6: If "Other", please specify.	F24	Yes
Initative 4 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	F25	Yes
Initative 4 - B8: Report on progress to date:	F26	Yes
Initative 5 - B1: Individual title	G18	Yes
Initative 5 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	G19	Yes
Initative 5 - B3: 2017-18 Project names as provided in the 2017-18 returns.	G21	No
Initative 5 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	G22	Yes
Initative 5 - B5: Which of the following categories the initiative / project primarily falls under.	G23	Yes
Initative 5 - B6: If "Other", please specify.	G24	Yes
Initative 5 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	G25	Yes
Initative 5 - B8: Report on progress to date:	G26	Yes
Initative 6 - B1: Individual title	H18	Yes
Initative 6 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	H19	Yes
Initative 6 - B3: 2017-18 Project names as provided in the 2017-18 returns.	H21	Yes
Initative 6 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	H22	Yes
Initative 6 - B5: Which of the following categories the initiative / project primarily falls under.	H23	Yes
Initative 6 - B6: If "Other", please specify.	H24	Yes
Initative 6 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	H25	Yes
Initative 6 - B8: Report on progress to date:	H26	Yes
Initative 7 - B1: Individual title	I18	Yes
Initative 7 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	I19	Yes
Initative 7 - B3: 2017-18 Project names as provided in the 2017-18 returns.	I21	Yes
Initative 7 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	I22	Yes
Initative 7 - B5: Which of the following categories the initiative / project primarily falls under.	I23	Yes
Initative 7 - B6: If "Other", please specify.	I24	Yes
Initative 7 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	I25	Yes
Initative 7 - B8: Report on progress to date:	I26	Yes
Initative 8 - B1: Individual title	J18	Yes
Initative 8 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	J19	Yes
Initative 8 - B3: 2017-18 Project names as provided in the 2017-18 returns.	J21	Yes
Initative 8 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	J22	Yes
Initative 8 - B5: Which of the following categories the initiative / project primarily falls under.	J23	Yes
Initative 8 - B6: If "Other", please specify.	J24	Yes
Initative 8 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	J25	Yes
Initative 8 - B8: Report on progress to date:	J26	Yes
Initative 9 - B1: Individual title	K18	Yes
Initative 9 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	K19	Yes
Initative 9 - B3: 2017-18 Project names as provided in the 2017-18 returns.	K21	Yes
Initative 9 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	K22	Yes
Initative 9 - B5: Which of the following categories the initiative / project primarily falls under.	K23	Yes
Initative 9 - B6: If "Other", please specify.	K24	Yes
Initative 9 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	K25	Yes
Initative 9 - B8: Report on progress to date:	K26	Yes
Initative 10 - B1: Individual title	L18	Yes
Initative 10 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	L19	Yes
Initative 10 - B3: 2017-18 Project names as provided in the 2017-18 returns.	L21	Yes
Initative 10 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	L22	Yes
Initative 10 - B5: Which of the following categories the initiative / project primarily falls under.	L23	Yes
Initative 10 - B6: If "Other", please specify.	L24	Yes
Initative 10 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	L25	Yes
Initative 10 - B8: Report on progress to date:	L26	Yes

Sheet Complete:	No

6. iBCF Part 2

	Cell Reference	Checker
C) a) The number of home care packages provided for the whole of 2018-19	D11	Yes
C) b) The number of hours of home care provided for the whole of 2018-19	E11	Yes
C) c) The number of care home placements for the whole of 2018-19	F11	Yes
D) Metric 1	C18	Yes

Sheet Complete:	Yes

^^ Link Back to top

Better Care Fund Template Q1 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Nottingham

Confirmation of Nation 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 Q1 2018/19

Metrics

Selected Health and Wellbeing Board: Nottingham

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Data not available to assess progress	Only April data is available at the time of reporting. Investigative work on non-elective trends over winter is ongoing, with clear increases identified in respiratory illness for the youngest and oldest citizens, and an increase in sepsis diagnosis following TTR (Think, Treat, Review) project work in NUH: https://www.nuh.nhs.uk/latest-news/meet-sally-and-abby-part-of-nuhs-sepsis-team-2640	It is important to note that while we have seen increases in NEA over the winter period, performance remains within expected variation.	N/A
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	N/A	Residential admissions data is available for April and May at the time of writing. Admissions are green for the quarter and for the year to date, and well within year target of of 384. This reflects a programme of work within the local authority to reduce residential admissions following hospital admission. Work is ongoing to identify and quantify potential cost shifts to homecare, community beds and community nursing as a result of the large difference between 16-17 and 17-18 performance.	N/A
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	N/A	Reablement data is available for April and May at the time of writing. Reablement is green for April and May, with extremely high performance for the quarter so far and for the year to date. A data quality check has been completed for Reablement this quarter.	N/A
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Data not available to assess progress	Only April data is available at the time of reporting. Analysis of the reasons for delay shows a bottleneck in waits for homecare packages in social care, and in community bed waits in the NHS.	Work on Patient Choice alongside NHS elect, and on the discharge pathway alongside Newton Europe, is underway with both pieces of work at reporting stage.	N/A

Better Care Fund Template Q1 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Nottingham

Challenges Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs Please indicate any support that may better facilitate or accelerate the implementation of this change

		Maturity Assessment						Narrative		
		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Established	Established	Established	Established	Established		The changes in attitude, behaviour and culture (AB&C) is recognised as a challenge across the system. Should there not be a a shared sense of purpose with clear communication across Greater Nottingham this will impact the success of Discharge to Assess (D2A). One communication package supporting implementation of D2A and for embedding 'Home First' mantra has been rolled out which provides consistency in language across the system and supports one electronic discharge plan (eTOC) that is being build in to Nerve centre for all members of the integrated discharge team (IDT) to access. Focussing of messaging to the public and staff across the system.	Weekly supported discharge target has been consistently met since launch of the IDT and D2A. Social care are inputting directly into nerve centre. "Extraordinary" complex patient review meetings (CPRM) are taking place thrice weekly.	IDT team leader has been appointed and will work with Bernie Brookes (external support) to develop the IDT, particularly those virtual members. D2A community capacity lead has also been appointed and will work in close collaboration with the IDT team leader.
Chg 2	Systems to monitor patient flow	Established	Established	Established	Established	Established		Systems reconfiguration to enable performance monitoring of the new metrics for D2A.	Red 2 Green is in place in NUH and across community rehabilitation/reablement providers and monitored monthly. Identifying pathways; simple/supported (1, 2 or 3). D2A metrics agreed and Dashboard framework in place with early data.	Systems reconfiguration to enable performance monitoring of the new metrics for D2A.
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established	Established	Established	Established	Established		The changes in attitude, behaviour and culture (AB&C) is recognised as a challenge across the system. Should there not be a a shared sense of purpose with clear communication across Greater Nottingham this will impact the success of Discharge to Assess (D2A). One communication package supporting implementation of D2A and for embedding 'Home First' mantra has been rolled out which provides consistency in language across the system and supports one electronic discharge plan (eTOC) that is being build in to Nerve centre for all members of the integrated discharge team (IDT) to access.	Weekly supported discharge target has been consistently met since launch of the IDT and D2A. Social care are inputting directly into nerve centre. "Extraordinary" complex patient review meetings (CPRM) are taking place thrice weekly.	IDT team leader has been appointed and will work with Bernie Brookes (external support) to develop the IDT, particularly those virtual members. D2A community capacity lead has been appointed and will work in close collaboration with the IDT team leader.
Chg 4	Home first/discharge to assess	Established	Established	Established	Established	Established		Intensive internal work continues to be completed w the external homecare providers to strengthen the resilience of the local home care market in order to ensure that there is sufficient capacity to meet all demand, including that from the community and from the acute hospital and community health providers.	Weekly supported discharge target has been consistently met with the exception of one week since launch of the IDT and D2A. Social care are inputting directly into nerve centre. "Extraordinary" complex patient review meetings (CPRM) are taking place on 3rd, 5th, 7th, 9th and 11th of January 2018.	IDT team leader has been appointed and will work with Bernie Brookes (ECIP support) to develop the IDT, particularly those vitural members. D2A community capacity lead has been appointed and will work in close collaboration with the IDT team leader.
Chg 5	Seven-day service	Plans in place	Plans in place	Plans in place	Plans in place	Plans in place		Workforce change to support 7 day services.	Call centre advice for care homes via 111 in place. Community services remain 7 day/week until 18:00 hrs. IDT worikforce employed by Nottingham University Hospital have moved to 7 day service	Workforce change to support 7 day services. Recruitment into the IDT ongoing.
Chg 6	Trusted assessors	Plans in place	Plans in place	Plans in place	Plans in place	Established		Trusted assessor actions are being led by County Council on behalf of the system	Trusted assessor actions are being led by County Council on behalf of the system	Trusted assessor actions are being led by County Council on behalf of the system
Chg 7	Focus on choice	Established	Established	Established	Established	Established		There remain a small number of citizens and families who do not wish to leave the bed based reablement facility to which they have been admitted following discharge from hospital. Continued work as a system is being completed to improve the frequency and consistency of information provided to citizens and their families in order to avoid citizens remaining in these facilities for longer than the expected 28 days.	System wide patient leaflet in use together with letter from senior clinician within NUH. PDMS set within 48 hours on day 1 of admission. Discharge planning happens on day 1 with the patient; no decision about me without me. Complex case manager x2 appointed to help manage this cohort of patients.	Review effectiveness of the leaflet quarterly and revise if necessary.
Chg 8	Enhancing health in care homes	Established	Established	Established	Established	Established		Large pool of small providers means roll-out of EHCH elements across all care homes in the City remains a challenge	Care homes red bag in place across Greater Nottingham. Pathfinder via NEMS. Use of skype as an option for a number of care homes. 111 advice line to support care homes.	Care homes will receive continued support from their respective CCG leads.

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.

		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on	Challenges	Achievements / Impact	Support needs
UEC	Red Bag scheme	Established	Established	Established	Established	Established		Nervousness around the loss of the bags themselves once they are physically on hospital premises has led to the development of a SOP which will be signed off at the task and finish group and circulated to the care homes.	Red bag scheme rolled out across Greater Nottingham care homes on 02.10.2017.	Care homes will receive continued support from their respective CCG leads.

Better Care Fund Template Q1 2018/19

5. Narrative

Selected Health and Wellbeing Board: Nottingham

Remaining Characters:	19,130

Progress against local plan for integration of health and social care

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Our latest highlight report (available on request) shows:
• Overall programme status: GREEN
• Performance is good, with 3 of 5 metrics showing green
• 18-19 budget work in progress
• KPIs for Q1 are green
• Newton Europe work underway
• NHS Elect work underway

Key programme level milestones:
Health and Social Care Scorecard: green
BCF Year end Outturn report: green
NHS Elect work on Patient Choice: green
Newton Europe work on DToC: green
BCF Plan Refresh: U (awaiting BCF Operating Guidance)

Key scheme-level milestones:
Assistive Technology - new eligibility criteria, paid-for service establishment: green
Carers - new contract delivery: green
Co-ordinated Care – mobilisation of new Neighbourhood Team model: green
Independence Pathway – Reablement Data Quality review: blue

BCF enablers:
Out of Hospital Reprocurement: green
Homecare Reprocurement: blue

Remaining Characters:	9,761

Integration success story highlight over the past quarter

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

The Housing to Health (H2H) project currently supports 2.5 Housing and Health Coordinator (HHCs) to integrate housing support within the local healthcare system. The H2H project was designed to provide the housing element of Integrated Care, preventing homelessness, reducing hospital admissions and readmissions, and improving the health of its patients. The project supports patients who are inappropriately housed, where the impact of their housing situation on their health and wellbeing is deemed to be such that they are at risk of admission to hospital, or where recovery from hospital care would be impossible at home and delays, readmission or a lengthy stay in a high-demand community bed would be the likely result. The HHCs take referrals from health and social care professionals, and from environmental health officers where the home is deemed unfit for habitation for health reasons.

Where appropriate, the HHCs support patients to be re-housed into social housing. The earliest aim of the scheme was to intervene at an early stage to support and enhance the best possible outcomes for patients and their carers. As the project began to embed within health systems, it developed an in-reach element which was able to work alongside health providers to identify patients in high-demand beds in acute and community settings who were likely to contribute to housing-related delays (2% of total DToC in 2016-17) as a result of unsuitable housing. Working alongside health providers, the H2H service was able to move these patients into more suitable properties in a timely manner, enabling recovery and reablement at home and minimising the clinical risks sometimes associated with delays in transfer of care.

2. Learning to date
The H2H service has been demonstrably successful to date, meeting and exceeding its objectives, and has been evaluated as providing a 6:1 return on investment through cost avoidance, reduction in delays and early intervention.
It has also been evaluated as delivering social value (at a rate of 26:1 SRI) and a series of benefits for patients using the service, reducing their hospital admissions, helping them to feel safer, happier, less socially isolated, more confident managing their own health, and more financially stable. It has also benefited their carers, improving wellbeing and life satisfaction (see section 5 below).
The project has produced a range of benefits to the health system, reducing costs by avoiding admissions, re-admissions and delayed discharges, supporting the move to out-of-hospital care and helping to manage patient flow through high-demand beds at a time of unparalleled pressure on these resources.

3. Improvements for 2018-19
The learning from the project to date allowed us to refine the existing health & housing support element within both community and acute discharge services, amending the model to focus directly on prevention within the community element and on flow through high-demand beds within the discharge element.
This amended model is designed to make the following improvements on the current model:
• it sets referral criteria to maximise health benefits through prevention of admissions and readmissions in the community, focusing on key patient populations identified through population health intelligence;
• it forms the housing element of the Integrated Discharge Function (IDF) within the acute setting, co-locating 1 WTE Housing Health Co-ordinator at NUH (co-funded by County BCF and covering both City and County patients) in order to support timely discharge and reduce the costs associated with Delayed Transfers of Care, according to the recommendations of NICE guideline NG27 .
These improvements are aimed at maximising the health system benefits of every referral and ensuring the clinical risks associated with unsuitable housing are managed appropriately and in line with wider health priorities and ongoing key workstreams in Greater Nottingham.

4. Case for change
4.1. Drivers of amended model:
• While the H2H project has already had a level of success with an in-reach model, unmet need remains and bed days are still lost to housing related delays and a co-located WTE HHC would bring additional benefits;
• There is an identified need for a housing element to the IDF;

Better Care Fund Template Q1 2018/19

Additional improved Better Care Fund - Part 1

Selected Health and Wellbeing Board:	Nottingham
Additional improved Better Care Fund Allocation for 2018/19:	£ 4,430,143

Section A

What proportion of your additional iBCF funding for 2018-19 are you allocating towards each of the three purposes of the funding?	**a) Meeting adult social care needs**	**b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready**	**c) Ensuring that the local social care provider market is supported**
Please enter the amount you have designated for each purpose as **a percentage of the total additional iBCF funding you have been allocated for the whole of 2018-19.** If the expenditure covers more than one purpose, please categorise it according to the primary purpose. **Please ensure that the sum of the percentage figures entered does not exceed 100%. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell.**	24%	16%	60%

Section B

What initiatives / projects will your additional iBCF funding be used to support in 2018-19?	**Initiative/Project 1**	**Initiative/Project 2**	**Initiative/Project 3**	**Initiative/Project 4**	**Initiative/Project 5**	**Initiative/I**	**Initiativ**	**Initiative/**	**Initiative/I**	**Initiative/P**
B1) Provide individual titles for no more than 10 initiative / projects. If you are funding more than 10 initiatives / projects, you should list those with the largest size of investment in 2018-19. Please do not use more than 150 characters.	Supporting the local care provider market.	Complex needs homecare service	home care fee rates	Additional capacity and quality of reablement	Reviewing officer in homecare services					
B2) Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19? Use the drop-down menu, options below: Continuation New initiative/project	Continuation	Continuation	Continuation	New initiative/project	Continuation					
Click here for a reminder of initative / project titles submitted in Quarter 4 2017/18										
B3) If you have answered question B2 with "Continuation" please provide the name of the project as provided in the 2017-18 returns. See the link above for a reminder of the initiative / project titles submitted in Q4 2017-18. Please do not select the same project title more than once.										
B4) If this is a "New Initative / Project" for 2018/19, briefly describe the key objectives / expected outcomes. Please do not use more than 250 characters.				To support discharge to assess To increase the offer to more citizens To further improve the ambition of promoting independence creating better flow in the long term						
B5) Use the drop-down menu provided or type in one of the categories listed to indicate which of the following categories the initiative / project primarily falls under. Hover over this cell to view the comment box for the list of categories if drop-down options are not visible.	16. Stabilising social care provider market - fees uplift	6. Homecare	6. Homecare	13. Reablement	3. DTOC: Reducing delayed transfers of care					
B6) If you have answered question B5 with "Other", please specify. Please do not use more than 50 characters.										
B7) What is the planned total duration of each initiative/project? Use the drop-down menu, options below. For continuing projects, you should also include running time before 2018/19. 1) Less than 6 months 2) Between 6 months and 1 year 3) From 1 year up to 2 years 4) 2 years or longer	3. From 1 year up to 2 years	2. Between 6 months and 1 year	3. From 1 year up to 2 years	3. From 1 year up to 2 years	3. From 1 year up to 2 years					
B8) Use the drop-down options provided or type in one of the following options to report on progress to date: 1) Planning stage 2) In progress: no results yet 3) In progress: showing results 4) Completed	4. Completed	3. In progress: showing results	4. Completed	2. In progress: no results yet	3. In progress: showing results					

Better Care Fund Template Q1 2018/19

Additional improved Better Care Fund - Part 2

Selected Health and Wellbeing Board:	Nottingham
Additional improved Better Fund Allocation for 2018/19:	£ 4,430,143

Section C

What impact does the additional iBCF funding you have been allocated for 2018-19 have on the plans you have made for the following:			
	a) The number of home care packages provided for the whole of 2018-19:	**b) The number of hours of home care provided for the whole of 2018-19:**	**c) The number of care home placements for the whole of 2018-19:**
C1) Provide figures on the planned number of home care packages, hours of home care and number of care home placements you are purchasing/providing as a direct result of your additional iBCF funding allocation for 2018-19. The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please could you enter 0 in the appropriate box.	389	48,338	-

Section D

Indicate no more than five key metrics you will use to assess your performance.					
	Metric 1	**Metric 2**	**Metric 3**	**Metric 4**	**Metric 5**
D1) Provide a list of up to 5 metrics you are measuring yourself against. Please do not use more than 100 characters.	#referrals into Acute/Community Reablement Services	#referrals into Homecare services	#hours of homecare provided including internal and external services		

Better Care Fund Template Q1 2018/19

Additional iBCF Q4 2017/18 Project Titles

Selected Health and Wellbeing Board: Nottingham

[<< Link to 6. iBCF Part 1]

Quarter 4 2017/18 Submitted Project Titles

Project information not submitted in 2017-18 reporting

Project Title 1	Project Title 2	Project Title 3	Project Title 4	Project Title 5	Project Title 6	Project Title 7
Supporting the local care provider market.	Complex needs homecare service.	Home care fee rates	Meeting adult social care needs through increased demand and complexity of care provision.	Reviewing officers in homecare services.		

Project Title 16	Project Title 17	Project Title 18	Project Title 19	Project Title 20	Project Title 21	Project Title 22

Project Title 8	Project Title 9	Project Title 10	Project Title 11	Project Title 12	Project Title 13	Project Title 14	Project Title 15

Project Title 23	Project Title 24	Project Title 25	Project Title 26	Project Title 27	Project Title 28	Project Title 29	Project Title 30