Better Care Fund Template Q2 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 (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.

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=KoYZPXmUJHE

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

For 2018-19 the additional iBCF monitoring has been incorporated into the BCF form. Please fill this section in 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.

For Quarter 2, the iBCF section of the form covers questions relating to external provider fees only. Specific guidance is provide on the iBCF tab.

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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:	Clare Rourke
E-mail:	clare.rourke@nhs.net
Contact number:	01158839575
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'

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
6. iBCF	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

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	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

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	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

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	Cell Reference	Checker
Chg 1 - Early discharge planning Q2 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q2 18/19	F15	Yes
Chg 5 - Seven-day service Q2 18/19	F16	Yes
Chg 6 - Trusted assessors Q2 18/19	F17	Yes
Chg 7 - Focus on choice Q2 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q2 18/19	F19	Yes
UEC - Red Bag scheme Q2 18/19	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

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	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

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	Cell Reference	Checker
1. Average amount paid to external providers for home care in 2017/18	C19	Yes
1. Average amount expected to pay external providers for home care in 2018/19	D19	Yes
1. Uplift if rates not known	E19	Yes
2. Average amount paid for external provider care homes without nursing for clients aged 65+ in 17/18	C20	Yes
2. Average expected pay for external provider care homes without nursing clients aged 65+ in 2018/19	D20	Yes
2. Uplift if rates not known	E20	Yes
3. Average amount paid for external provider care homes with nursing for clients aged 65+ in 2017/18	C21	Yes
3. Average expected to pay for external provider care homes with nursing for clients aged 65+ in 18/19	D21	Yes
3. Uplift if rates not known	E21	Yes

Sheet Complete:	Yes

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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		

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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	Not on track to meet target	September data was not available at the time of reporting. NEA are 6.9% above plan for Q2 as of August. Largely, the increase in admissions is found in same day and short stay at NUH. NEAs for paediatrics (33%), General Surgery (27%), and Respiratory Medicine (14%) are exceeding the agreed contractual plan for Nottingham City CCG at August YTD	N/A	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 July and August at the time of writing; admissions are green for the year to date and well within the year end target of of 384, YTD at August is 52	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	Further work is being undertaken to investigate the data in more detail, and compare this to Nottinghamshire to ensure it is robust.	Reablement data is available for July and August at the time of writing. Reablement is currently above target for Q2 at 93.3% and above target for the YTD	n/a
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	n/a	DTOC data for July and August shows that the metric is meeting the target for Q2 to date	n/a

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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	Q2 18/19 (Current)	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		Increased referrals for Pathway 1 has resulted in marked delay in home care packages in Nottingham City (to be reported via the Nottingham City BCF Quarterly Submission). Recent empty beds in community bed provision. Action plan in place to optimise capacity. Previous agreement to progress the Lancashire model, but now due to funding this is unable to be progressed at the moment.	- Emergency admissions have a predicated discharge date set within 48hrs of being admitted and are identified as being a "simple" or "supported discharge". - 250 supported discharges weekly. Reduced DTOC to lowest number ever, as well as reduced Medically Stable For Discharge >24hrs. - Average length of stay post Medically Stable For Discharge @ 2.2days. - Joint DTOC coding Standard Operating Procedure agreed across all organisations. - Multiagency training 'excellence in discharge planning' "trolley dash" education. - Education events planned with NHS Elect for IDF. Increased referral onto Pathway 1, reduced requirements for Pathway 2. - Red bag scheme in operation across the South. - Front Door Discharge team (12fte) work holistically (trained through Citycare competencies framework) and refer direct to START and Leivers accept "Transfer of Care" form for admission to Leivers - County Social Care Home First Response Service 7 day service to bridge capacity OF Homecare and START - All City citizens are discharged home with NCC Social Care Reablement services to maximise reablement potential. OT services are based within SCR to assess and review and free up homecare capacity across SCR and external provision	Development of the Lancashire model to promote home first further within a safe and effective system. Paper to be presented at A&E Delivery Board as part of the wider funding discussion / requirements to support system flow. Increased capacity for an at home model required to increase the number of people going home and staying at home with support.
Chg 2	Systems to monitor patient flow	Established	Established	Established	Established	Established		Care home live bed management system recommended to provide real time bed capacity within care homes. Funding stream to be discussed at A&E Delivery Board. The Home First Dashboard is to be reviewed with system partners to ensure it is accurate. Providers are contracted to complete the metrics to ensure the dashboard is meaningful, providing a true picture of system flow for the whole patient journey from admission to discharge.	- Newton Europe review completed. Clinical Utilisation Review -recommendations completed. - 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. - Nerve Centre at NUHT provides partners with the status information on patients that are allocated to them to review - All supported discharges are triaged daily by health and social care within the Integrated Discharge Team - Nerve Centre provides bed capacity live data to monitor flow - County Social Care have an escalation plan and daily dashboard in place across social care teams within NUHT and wider services such as START/STIS/Leivers/Homefirst/Homecare - Allows managers to be proactive and flex resources where they are needed. It also provides a framework with clear processes when capacity across these services is full. This allows social care to be proactive when reacting to the Opel status at NUHT - Nottingham City are embedded in the IDT and are able to view all patient flow systems daily, citizens exiting the acute trust then move into social care reablement and this workflow is monitored via out electronic recording system. We have a surge and escalation action plan in place.	Clarity regarding funding is required. D2A development has provided benefits for all system partners, therefore discussion about how all system partners support further developments.
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established	Established	Established	Established	Established		Challenges to reduce DSTs in hospital to <15%.Progress being made to reduce DSTs in hospital. Work progressing with stroke to reduce the requests for DSTs and mental health patients.	- Integrated Discharge Team across NUHT/Social Care (City/County)/Community health staff formed in October 2017 - IDT are working together to ensure appropriate plans are in place for all 'stranded' and super stranded' patients. - Thrice weekly health and social care meeting to look at top 20 on medically safe to ensure plans for discharge are in place with accountable lead. - Transfer Action Groups within NUH across the Divisions are in place. - Weekly complex patient review meeting with senior system partners to 'unlock' any issues with discharge plans. - Stranded and super stranded senior meeting taking place daily for 2 weeks - 98 patients reviewed, 28 discharged with a length of stay between 20-344 days. - Discussions with stroke services to promote D2A have been positive. Increased referrals for stroke beds since seen.	Education events have resulted in a reduction of DSTs being carried out in the acute environment. Issues identified within mental health as this is still classed as an 'acute environment'. Discussions with the central team have further clarified that patients in Highbury and equivalent facilities are not a sub acute environment, therefore contribute to the 15%. Work planned to develop D2A principles across the Healthcare Trust inpatient beds. Increase in discharge to assess beds from stroke will develop a waiting list. CCG contracts team aware of this and will monitor community bed capacity closely.
Chg 4	Home first/discharge to assess	Established	Established	Established	Established	Established		Increased demand for home care package as part of home first.	- Weekly supported discharge target has been consistently achieved since October 2017. - One single "transfer of care " form agreed by all parties to discharge patients on pathway 2+3 - Home first ethos being embedded and leaflet to embrace home first developed	Discharge policy supported by all organisations. Letters will be generated as part of the discharge policy. Need to ensure the PALS teams are aware to ensure changes are communicated to patients as a result of enacting the discharge policy. Nottingham City home care

Chg 5	**Seven-day service**	Plans in place	Plans in place	Established	Established	Established		Workforce change to support 7 day services. Whilst some services are in place to support 7-day working it is recognised there are gaps.	- Provider group working through this to put in place appropriate plans that should come into fruition prior to Winter. - County Social Care have a Rota system in place to cover weekend working -Work ongoing to develop 7/7 service for IDT in NUH, however funding required for additional staff to support this. Plan to extend the weekday working until 6pm.	Providing a 7/7 service across the IDF requires additional funding.
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Plans in place	Plans in place	Plans in place		Trusted assessor actions for care homes are being led by County Council on behalf of the system	- A Trusted Assessor model is progressing as a function within the Integrated Discharge Team at NUHT, with health and social care colleagues developing a set of competencies and a bespoke training package to allow this multidisciplinary team to complete a "Transfer of Care "document to determine the pathway of a patient on each other's behalf. The "Transfer of Care "document has all the relevant information to allow a provider to accept the patient into their care in the community. - Nottinghamshire County Council is also leading on a Trusted Assessor model for Care Homes, where the Nottinghamshire Care Association are recruiting Trusted Assessor to independently assess patients on behalf of care home managers for a six month pilot. Interviews taking place this week.	Trusted assessor actions for care homes are being led by County Council on behalf of the system - CCGs to support development.
Chg 7	**Focus on choice**	Established	Established	Plans in place	Established	Established		Support for staff when implementing the discharge policy. Training programme to be agreed with providers to enable staff to enact the Discharge Policy and consistently deliver the same messages about leaving hospital and support required to enact it.	- Discharge policy ratified by A&E delivery Board on 4 September 2018 and agreed by all providers. - Connect worker insitu at QMC/City to accept referrals from social care - Patient choice event has provided tools to increase communication with patients regarding patient choice	Training plan in place to implement the discharge policy.
Chg 8	**Enhancing health in care homes**	Established	Established	Plans in place	Established	Established		Enhanced care service to care homes in County, review of service for Nottingham City who decommissioned their enhanced service from 1 April 2018. Need to monitor if any impact, i.e. increased ED activity.	- STP Urgent & Emergency Care Group agreed to prioritise 'frequent activity' in all areas, which includes care homes. - The BCF fund Optimum to work with care homes to enhance care and avoid admissions - Established champions to train staff in identifying signs and actions to take to reduce hospital admissions. - Spot purchase care home bed framework and escalation being developed, to ensure contingency for times of escalation and greater community bed demands.	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	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 alternative	Challenges	Achievements / Impact	Support needs
UEC	**Red Bag scheme**	Established	Established	Established	Established	Established		Ongoing work to ensure repatriation of red bags to care homes following the death of a resident in hospital.	Red bag scheme rolled out across Greater Nottingham care homes on 02.10.2017. All frail older patient care homes aware and engaging with project. Many using the red bag as well as all the accompanying paperwork such as CARES escalation record.	Care homes will receive continued support from their respective CCG leads. Further funding for additional care homes being built. Responsibility of repatriation of red bags to be discussed.

Better Care Fund Template Q2 2018/19

5. Narrative

Selected Health and Wellbeing Board: Nottingham

Remaining Characters:	19,434

Progress against local plan for integration of health and social care

Our latest highlight report (available on request) shows:
• Overall programme status: GREEN
• Performance is good, with 3 of 5 metrics showing green with month 7 activity showing 4 of 5 metrics as green
• 18-19 budgets are now set and agreed via Health and Wellbeing Board
• Newton Europe system report to be available at the end of the month
• The Nottingham City Out of Hospital contract is now mobilised and we continue to work with the provider to indentify new opportunities to integrated services or process to avoid duplication across 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.

Remaining Characters:	15,194

Integration success story highlight over the past quarter

Carers
In 2016 Nottingham City had a range of carer support services, separately commissioned by Nottingham City Council and NHS Nottingham City CCG and funded through the BCF. The services were individually well-regarded, but lacked overall cohesion. As part of a 2016 strategic commissioning review, carried out jointly by Nottingham City Council and CCG, we identified that there were gaps and duplications in the services, which was confusing to both carers and professionals. New responsibilities from The Care Act 2014 gave local authorities a duty to identify carers, and offer statutory Carers Assessments to all carers - including carers of citizens who are not receiving social care support. Carrying out such assessments through Adult Social Care would be time-intensive, and assessments may focus on the needs of the cared-for citizen rather than the carer.

Nottingham City's model of support
Nottingham City Council and NHS Nottingham City CCG jointly commissioned three services for carers. This included the Nottinghamshire Carers Hub, an integrated service across Nottingham and Nottinghamshire, providing information, advice and support through a single point of contact for carers across

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.

Better Care Fund Template Q2 2018/19

6. Additional improved Better Care Fund

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

These questions cover average fees paid by your local authority (including client contributions) to external care providers.
We are interested only in the average fees actually received by external care providers from local authorities for their own supported clients (including client contributions). The averages should therefore exclude:
-Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. the local authorities' own staff costs in managing the commissioning of places
-Any amounts that are paid from sources other than the local authorities' funding (including client contributions), i.e. you should exclude third party top-ups, NHS Funded Nursing Care and full cost paying clients.

The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.
This single average should include fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:

1. Take the number of clients receiving the service for each detailed category.
2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).
3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.
4. For each service type, sum the resultant detailed category figures from Step 3.

If you are unable to provide rates for both 2017/18 and 2018/19, please ensure that you provide the estimated percentage change between 2017/18 and 2018/19 in the table below. Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	2017/18	2018/19	If rates not yet known, please provide the estimated uplift as a percentage change between 2017/18 and 2018/19
1. Please provide the average amount that you paid to external providers for home care in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per contact hour, following the exclusions as in the instructions above)	£ 15.52	£ 15.80	
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions as in the instructions above)	£ 551	£ 569	
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions in the instructions above)	£ 578	£ 607	
4. If you would like to provide any additional commentary on the fee information provided please do so. Please do not use more than 250 characters.	The average costs for Residential / Nursing are for long term placements only and do not include citizens with a primary support reason of Mental Health or Learning Disability.		