Better Care Fund Template Q2 2017/18

Guidance

Overview

The Better Care Fund (BCF) quarterly monitoring template is used to ensure that Health and Wellbeing Board areas continue to meet the requirements of the BCF over the lifetime of their plan and enable areas to provide insight on health and social integration.

The local governance mechanism for the BCF is the Health and Wellbeing Board, which should sign off the report or make appropriate arrangements to delegate this.

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 cell

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.

If required, the row heights can be adjusted to fit and view text more comfortably for the cells that require narrative information. Please note that the column widths are not flexible.

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 (hyperlinked) 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 onfirming 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 17/19, 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 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
- DToC: The BCF plan targets for DToC for the current year 17/18 should be referenced against the agreed trajectory submitted on the separate DToC monthly collection template for 17/18.
The progress narrative should be reported against this agreed monthly trajectory as part of the HWB's plan

When providing the narrative on challenges and achievements, 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 areas to implement the High Impact Change Model for Managing Transfer of Care. Please identify your local system's current level of maturity for each of the eight change areas for the reported quarter and the planned / expected level of maturity for the subsequent quarters in this year.

The maturity levels utilised are the ones described in the High Impact Changes Model (link below) and an explanation for each 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

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide further detail on the initiatives implemented and related actions 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 and any impact to highlight, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

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 is currently in draft format. Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team. 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.

Better Care Fund Template Q2 2017/18

1. Cover

Version 1

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Gateshead
Completed by:	Hilary Bellwood/JohnCostello
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Contact number:	0191 217 2960
Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Lynne Caffrey Chair Gateshead Health and Wellbeing Board

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

Complete

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

Better Care Fund Template Q2 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Gateshead

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

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	No	As full approval of our BCF submission was received on 27 October, arrangements are now being put in place to finalise a S75 pooled budget agreement for our BCF 2017-19, similar to the pooled fund arrangements previously in place. It is envisaged that this will be progressed in parallel to the finalisation and sign-off of a S75 agreement for a 'Continuing Health Care and Funded Nursing Care Lead Commissioning and Procurement Service'. The date identified within the next column refers to expected sign-off date of both S75 agreements. This is consistent with a key theme of our BCF submission that the BCF forms part of a broader picture in working towards the integration of health and care services and therefore should not be seen in isolation.	31/12/17

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3. Metrics

Selected Health and Well Being Board: Gateshead

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	The current projection for this metric is on track to meet this target, however the impact of the forthcoming winter months and the resultant additional demands on the health and social care system will mean that maintaining this trajectory will be challenging.	Non Elective admissions year to date to Q2 are circa 9.3% below planned levels.	None identified
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	The increasing ageing population will continue to pose a challenge, half of the permanent admissions during April to September 2017 were for people aged 85 and over, a trend which has remained consistent over the last 3 years. In addition, the number of people being admitted to EMI residential care is showing an increase compared to 2015/16 (47% 2017/18 compared to 42% 2015/16).	During the period of April to September 2017 there have been 145 admissions into permanent care. This represents 372.5 admissions per 100,000 populations (65+). This is an improvement in performance compared to the same point last year, where there were 161 permanent admissions (420.0 per 100,000 population). Performance is currently on track to meet the yearend target of 950.5 per 100k (370 admissions). The implementation of a panel process which provides greater scrutiny has helped to reduce permanent admissions. A pilot for using in house domiciliary care services and care call to support overnight needs has enabled people to remain at home rather than go into 24 hour care. The pilot has supported 21 people so far, for an average of 15 nights. 17 of the 21 people (81%) supported through this pilot had no planned overnight needs and	None identified
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	We have made incremantal improvements in achieveing this target and if current performance is maintained we expect to meet the target in Q3	The indicator value stands at 85.1% (297 out of 349) for all of those aged 65 and over that were discharged from hospital into reablement during January and June 2017 and still at home 91 days later. Performance has improved compared to the same period last year, which was 79.2% (347 out of 438) and is close to the 2017/18 target of 85.6%. There have been increased admissions within PRIME (in house enablement service) in alignment with further Enablement employees trained in TSI, a leading technique in reducing the provision of support to clients	None identified
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	On track to meet target	Whilst we have had comprehensive plans in place, the lead in time for recruitment to posts and the full establishment of all interventions did not take place until September 2017. We have made incremantal improvements in achieveing this target and we expect to maintain current performance now that plans are fully in place.Concerns over revised trajectory indicated in the letter dated 9th November 2017 from the North Winter Office	The average number of delays per day, per 100,000 population for September 2017 is 6.89, for delays attributable to Social care and NHS. This is within the monthly target of 8.2 per 100k for September 2017. Performance has improved significantly compared to the same point last year, where the equivalent rate was 13.5 per 100k. 5.6 per 100k population were delayed on average per day, where the NHS was attributable which is slightly over the target of 5.5. This is an improved position compared to the same time last year (5.9) For Social care, the average number of delays per day for September 2017 was 1.3 per 100k. This is within target of 2.6 per 100k population and shows significant improvement compared to the same time last year (7.6). We have significantly reduced the number of delayed days in Q2 although we have not met the	None identified

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

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4. High Impact Change Model

Selected Health and Well Being Board: Gateshead

		Maturity assessment			Narrative			
		Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Mature	Mature	Mature	Regular reviews of the SAFER bundle to ensure it continues to be effectively implemented. Daily Board/Ward rounds include identification of patients with nearing EDD's in order that their discharge can be planned with the appropriate support provided in the community if necessary. Work to be undertaken to achieve greater standardisation of how SAFER was initially embedded and draw in latest good practice emerging.	Patients who need to be repatriated or dischargd to other CCG/LA areas continue to be an issue and impact on flow.	Integrated working now takes place between community based and acute medical teams to ensure patients can continue on their journey/pathway of care, have a co-ordinated plan in place and are discharged within an appropriate time frame.	Adherence to the regional Repatriation policy by out of area providers.
Chg 2	**Systems to monitor patient flow**	Mature	Mature	Mature	Patient flow is monitored regularly (inc. EDD v actual discharge dates) using an electronic dasboard being trialled on ward 9 which displays live data at ward level to support proactive discharging. This enables all health and care teams to have daily discussions in order to expedite the discharge of medically optimised patients so that they do not become a DToC. A weekly/daily surge group meets when required. Plans to roll out live electronic ward reporting of key flow metrics to be influenced at ward level supported by Performance Improvement Plan.	Work will continue to optimise the discharge pathway.	Work has been undertaken with services/teams to develop more effective pathways/processes to access resources and support which cause bottlenecks. Local targets now developed and embedded into working practices which are monitored (real time); All relevant staff - whatever the setting - will at all times fully understand the pressures being experienced by the whole system and will adjust their working practice to ensure effective patient flows.	None identified at this stage

Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Mature	Mature		Whilst good progress is being made in Gateshead, there is an inconsistent approach in other LA/CCG areas which impact on the flow of patients locally (casuing bed capacity issues).	An integrated service delivery model has been developed to support a MDT approach with joint assessment and discharge process. Frailty team is now operational 7 days working alongside other professionals.	None identified at this stage
Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Plans in place		A review of the current Intermediate Care Service model is being undertaken to ensure that sufficient discharge management and alternative capacity is available.	Schemes have been established (funded through IBCF) which include a Bridging Service to enable patients to be discharged home without delys, whilst a 'Home First' pathway has been developed across all acute wards with social care and community services support.	None identified at this stage
Chg 5	**Seven-day service**	Plans in place	Plans in place	Plans in place		Challenges with sustaining capacity across certain parts of the system and interfaces between servcies	Specified support services are now available 7 days a week to ensure the next steps in the patients care pathway, as determined by the daily consultant led review are implemented. This includes a more responsive care home sector.	None identified at this stage
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Plans in place		A model of trusted assessor has been developed between the Council and the Trust, which is to go live on 20.11.17. Initially ward based assessments will be coordindated by Discharge Liaison Nurses, who will then refer into the Local Authority enablement services, removing the need for social care assessment, in order to access enablement support.	An integrated single process has been developed locally so that no separate organisational sign off is necessary to ensure no delays in discharge. Workstreams now in place to progress trusted assessment to access enablement services, develop acute-community stroke direct pathways and establish trusted assessment with care home providers.	None identified at this stage
Chg 7	**Focus on choice**	Mature	Mature	Mature	Choice protocol is in place and understood by staff, however this is under review. Planning for discharge begins on admission to ensure appropriate flow is maintained whilst community and social care teams work with acute teams to support people home from hospital.	Whilst there has been much progress locally, there is an inconsistent approach by other CCGS/LA areas which impacts on local patient flows and bed capacity.	Local policy has been reviewed in collaboration with local stakeholders and patient representatives. Work has also been undertaken on the information provided to patients and families at the start of their acute stay to ensure clairty about entiltlements and the options when medically fit for discharge. Legal advice being sought regarding the number of days provided to decision making (Gateshead)	National Choice policy should be developed to ensure standardisation wherever a patient is being cared for.

Chg 8	**Enhancing health in care homes**	Mature	Mature	Mature	Newcastle and Gateshead have well developed enhanced care home services including link practices [100% in Ghd and 60% in Ncle]. Care delivery has been further enhanced by focussing on all elements of the EHCH Framework over the past couple of years while working as part of the national Care Home Vanguard Programme]. Most elements are exemplary/well established while others are new and planned. All of the metrics linked to the Vanguard Programme are being achieved.	Ensuring the momentum and focus of work continues in the post Vanguard world.	All metrics of Vanguard programme are being met with current quarter data revealing: lowest rate of hospital admissions for residents with urine infection for 2 years, reduction in oral nutritional supplement prescribing, reduction in low dose antipsychotic prescribing, reduction in care home residents dying in hospital, levelling of A&E attendance.	Support to continue the journey so as to influence the lives of older people living with frailty wherever they might live (not just in care homes)is expected to come from the planned regional frailty plans.

Hospital Transfer Protocol (or the Red Bag Scheme) Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.								
		Q2 17/18 (Current)	**Q3 17/18 (Planned)**	**Q4 17/18 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Plans in place	Plans in place	Established		• Successfully implementing the launch plan, giving common messages and gaining common understanding • System benefits aren't seen	Transfer of care bags have been purchased for all residential and nursing care homes in Newcastle and Gateshead. A launch plan is in place and launch products have been developed. Currently the transfer or care forms are being tested and once evaluated a date will be agreed to begin the launch campaign. All products are being prepared without logos to share with NHSE local area team who have a plan to	None anticipated.

Better Care Fund Template Q2 2017/18

5. Narrative

Selected Health and Wellbeing Board: Gateshead

Remaining Characters:	16,670

Progress against local plan for integration of health and social care

At the heart of our vision and plan for integration is recognition that our Health and Social Care System requires new models of care delivery that enable collaboration across care settings, underpinned by sustainable, person centred co-ordinated care.

We said in our BCF plan that we must also build upon the already well established working arrangements across Gateshead – there are not only good interagency relationships at all levels of organisations, but also great examples of joint working and innovation to be capitalised upon; for example, the development of the Gateshead Care Partnership which is an innovative partnership formed between the system to deliver integrated community services for Gateshead residents.

Out of hospital care and support will be underpinned by a 'joined-up' system, with services across general practice, community services, mental health and social care delivering support to people that is coordinated. We also said that a strong, responsive intermediate system would further provide foundations for the development of the out of hospital model and strengthening and supporting our social care and VSCE sector together with a robust, responsive and sustainable domiciliary and reablement care would be a crucial component.

There is good progress being made in implementing our vision for integration. On 8 September the health and wellbeing board approved the direction of travel for integrating health and care in Gateshead including the establishment of a Gateshead Health and System Board to further develop the thinking. There are four workstreams interlinked, provider development, commissioner development, system architecture and governance. The three main objectives are to shift the balance of services from acute and crisis interventions to community support focusing on prevention and early help, support development of integrated care and treatment for people with complex conditions and ensure effective, efficient and economically secure services during a period of continued public sector austerity.

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:	18,537

Integration success story highlight over the past quarter

We are pleased to be able to report that we have plans in place for the Hospital Transfer Protocol with our Black Bag Scheme in order to enhance communication and information sharing when residents move between care settings and hospital.

The transfer of care bags have been purchased for all residential and nursing care homes in Newcastle and Gateshead. All products are being prepared without logos to share with NHSE local area team who have a plan to roll out the bags in all other areas In terms of timescales, we expect to continue with the comms until December then issue them in January

A pilot for using in house domiciliary care services and care call to support overnight needs has enabled people to remain at home rather than go into 24 hour care. The pilot has supported 21 people so far, for an average of 15 nights. 17 of the 21 people (81%) supported through this pilot had no ongoing overnight needs and remained at home.

A Telecare operator is now positioned in the Adult Social Care front door team, preserving people at home through the provision of assistive technology.

While not directly related to iBCF funding there are also examples of integration from a parity of esteem perspective within Deciding together Delivering together (transformation of local adult mental health services) involving mental health foundation trusts, acute foundation trusts, local authority, third sector, primary care, users carers and Healthwatch.

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 2017/18

Checklist

<< Link to Guidance tab

Complete Template

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

	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? If no please 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

	Cell Reference	Checker
NEA Target performance	D7	Yes
Res Admissions Target performance	D8	Yes
Reablement Target performance	D9	Yes
DToC Target performance	D10	Yes
NEA Challenges	E7	Yes
Res Admissions Challenges	E8	Yes
Reablement Challenges	E9	Yes
DToC Challenges	E10	Yes
NEA Achievements	F7	Yes
Res Admissions Achievements	F8	Yes
Reablement Achievements	F9	Yes
DToC Achievements	F10	Yes
NEA Support Needs	G7	Yes
Res Admissions Support Needs	G8	Yes
Reablement Support Needs	G9	Yes
DToC Support Needs	G10	Yes

Sheet Complete:	Yes

4. HICM

	Cell Reference	Checker
Early discharge planning Q2	D8	Yes
Systems to monitor patient flow Q2	D9	Yes
Multi-disciplinary/multi-agency discharge teams Q2	D10	Yes
Home first/discharge to assess Q2	D11	Yes
Seven-day service Q2	D12	Yes
Trusted assessors Q2	D13	Yes
Focus on choice Q2	D14	Yes
Enhancing health in care homes Q2	D15	Yes
Red Bag scheme Q2	D19	Yes
Early discharge planning, if Mature or Exemplary please explain	G8	Yes
Systems to monitor patient flow, if Mature or Exemplary please explain	G9	Yes
Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain	G10	Yes
Home first/discharge to assess, if Mature or Exemplary please explain	G11	Yes
Seven-day service, if Mature or Exemplary please explain	G12	Yes
Trusted assessors, if Mature or Exemplary please explain	G13	Yes
Focus on choice, if Mature or Exemplary please explain	G14	Yes
Enhancing health in care homes, if Mature or Exemplary please explain	G15	Yes
Red Bag scheme, if Mature or Exemplary please explain	G19	Yes
Early discharge planning Challenges	H8	Yes
Systems to monitor patient flow Challenges	H9	Yes
Multi-disciplinary/multi-agency discharge teams Challenges	H10	Yes
Home first/discharge to assess Challenges	H11	Yes
Seven-day service Challenges	H12	Yes
Trusted assessors Challenges	H13	Yes
Focus on choice Challenges	H14	Yes
Enhancing health in care homes Challenges	H15	Yes
Red Bag Scheme Challenges	H19	Yes
Early discharge planning Additional achievements	I8	Yes
Systems to monitor patient flow Additional achievements	I9	Yes
Multi-disciplinary/multi-agency discharge teams Additional achievements	I10	Yes
Home first/discharge to assess Additional achievements	I11	Yes
Seven-day service Additional achievements	I12	Yes
Trusted assessors Additional achievements	I13	Yes
Focus on choice Additional achievements	I14	Yes
Enhancing health in care homes Additional achievements	I15	Yes
Red Bag Scheme Additional achievements	I19	Yes
Early discharge planning Support needs	J8	Yes
Systems to monitor patient flow Support needs	J9	Yes
Multi-disciplinary/multi-agency discharge teams Support needs	J10	Yes
Home first/discharge to assess Support needs	J11	Yes
Seven-day service Support needs	J12	Yes
Trusted assessors Support needs	J13	Yes
Focus on choice Support needs	J14	Yes
Enhancing health in care homes Support needs	J15	Yes
Red Bag Scheme Support needs	J19	Yes

Sheet Complete:	Yes

5. Narrative

	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