Better Care Fund Template Q3 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.

Quarterly reporting for the 'improved Better Care Fund' (iBCF grant) will be required in Q4 18/19 and is not required for the current quarter Q3 18/19.

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.
3. When submitting your template, please also copy in your Better Care Manager.

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 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.

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1. Cover

Version 1.01

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:	Gateshead
Completed by:	Hilary Bellwood/John Costello
E-mail:	hilarybellwood@nhs.net
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 B

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

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 Q3 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19	F15	Yes
Chg 5 - Seven-day service Q3 18/19	F16	Yes
Chg 6 - Trusted assessors Q3 18/19	F17	Yes
Chg 7 - Focus on choice Q3 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19	F19	Yes
UEC - Red Bag scheme Q3 18/19	F23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	H12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	H13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	H14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	H15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	H16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	H16	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	H17	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	H18	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	H23	Yes
Chg 1 - Early discharge planning Challenges	I12	Yes
Chg 2 - Systems to monitor patient flow Challenges	I13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	I14	Yes
Chg 4 - Home first/discharge to assess Challenges	I15	Yes
Chg 5 - Seven-day service Challenges	I16	Yes
Chg 6 - Trusted assessors Challenges	I17	Yes
Chg 7 - Focus on choice Challenges	I18	Yes
Chg 8 - Enhancing health in care homes Challenges	I19	Yes
UEC - Red Bag Scheme Challenges	I23	Yes
Chg 1 - Early discharge planning Additional achievements	J12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	J14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	J15	Yes
Chg 5 - Seven-day service Additional achievements	J16	Yes
Chg 6 - Trusted assessors Additional achievements	J17	Yes
Chg 7 - Focus on choice Additional achievements	J18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	J19	Yes

UEC - Red Bag Scheme Additional achievements	J23	Yes
Chg 1 - Early discharge planning Support needs	K12	Yes
Chg 2 - Systems to monitor patient flow Support needs	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	K14	Yes
Chg 4 - Home first/discharge to assess Support needs	K15	Yes
Chg 5 - Seven-day service Support needs	K16	Yes
Chg 6 - Trusted assessors Support needs	K17	Yes
Chg 7 - Focus on choice Support needs	K18	Yes
Chg 8 - Enhancing health in care homes Support needs	K19	Yes
UEC - Red Bag Scheme Support needs	K23	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

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2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Gateshead

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: Gateshead

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	On track to meet target	National submission deadlines for BCF template are outside of SUS reporting periods and therefore the full picture for Q3 is not yet available. Only April-Oct data is currently available.	Whilst the full quarter 3 data is not yet available, Apr-Oct data was around 8% below planned levels, assuming that the plan for Q3 is equally shared across Oct-Dec.	None identified
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	The ageing population remains a constant challenge. This includes people who have dementia type illness whose needs are such that they cannot continue to live independently or with support, therefore requiring a 24 hour care setting environment. We are actively looking at developing an extra care scheme and are in discussions at present with a provider, that will accommodate people with a dementia type illness, which will further support a reduction in permanent admissions to care.	During the period of April to November 2018 there have been 205 admissions into permanent care. This represents 524.4 per 100,000 population (65+). This is a higher rate compared to the same point last year, where there were 192 permanent admissions (495.4 per 100,000 population). As per the expected trajectory, due to ageing population pressures. Performance is currently on track to meet the year end target of 854.4 per 100k (336 admissions).	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	On track to meet target	There is a need for increased care management support with complex mental health cases and to increase the effectiveness of our internal trusted assessor process. We will also work with commissioning colleagues for the ability to better source care packages with immediate effect and will also need to raise awareness with referrers that Enablement is removed from a time / task provision. The level of frailty of people using PRIME and PICs remains high Discourse is being held between Eastwood and Q.E. Ward 6 lead officers surrounding criteria of both services and pathways into Eastwood	Latest performance relates to April to November 2018. The indicator value stands at 88.3% (454 out of 514) for all those aged 65 and over that were discharged from hospital into reablement during January and August 2018 and still at home 91 days later. Performance has improved compared to the same period last year, which was 85.1% (404 out of 475) and is currently better than the 2018/19 plan of 87.9%.	None identified
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	The recent new target set for our local economy based on Q3 17/18 performance are very challenging. The ageing population remains a constant challenge, bringing an increase in frailty and we are also seeing an increase in older people with dementia. Support services for those younger people with a mental health illness such as housing is a challenge, which has an impact on delays. Recently there was a particular issue in the west of the borough accessing home care services, and on top of this where providers were able to obtain packages these were unable to commence immediately in some cases with delays of up to a week	Latest Performance relates to October 2018. The average number of delays per day, per 100,000 population for October 2018, is 8.3 for delays attributable to Social care and the NHS. This is outside the target of 4.0 per 100k population for October 2018. Performance has decreased compared to the same point for the previous year, where the equivalent rate was 3.57 per 100k population. The targets for 2018/19 are based on Q3 17/18 performance which was the quarter with the lowest DTOC rate for Gateshead in 17/18. 5.34 per 100k population were delayed on average per day, where the NHS was attributable which is outside the target of 2.7. This is a higher rate compared to the same point for the previous year (2.32) For Social care, the average number of delays per day for October 2018 was 2.98 per 100k. This is outside the target of 1.3 per 100k population and is higher than the same point for the previous year (1.26).	Regional approach to stabillising dom care market

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4. High Impact Change Model

Selected Health and Wellbeing Board: Gateshead

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

						Narrative			
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Mature	Mature	Mature	Mature	Regular reviews of the SAFER bundle to ensure it continues to be effectively implemented. Multi Disciplinary 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.	Evaluation of Regional Choice Policy not yet undertaken.	Work underway to implement use of new discharge checklists, new intranet support pages. Discharge forum, RE2GREEN and criteria led discharge. Reviews of long stay patients are starting to embed whilst ECIST will be visiting GHFT on 16th January.	Require final regional choice policy sign off locally although all documentation developed with escalation processes with agreed flow charts in place.
Chg 2	**Systems to monitor patient flow**	Mature	Mature	Mature	Mature	Patient flow is monitored regularly daily as part of site huddles. Still to establish and embed best approach to reveiwing stranded patients and embedding mental health screening assessment.	Various systems are in place to monitor flow however reports require tailoring to different audiences/users and this work is underway for 19/20 including the developing of live data for ward view.	All wards now have electronic whiteboards with long stay reporting now well established (review ongoing). Mental health screening is improving but new E-OBS will significantly improve electronic capture.	None identified at this stage
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Mature		Surge group and patient flow multi-agency group to review ways of working	Multi-agency Surge Group meeting regularly with Terms of Reference recenlty reviewed to provide escalation route for stranded/super stranded patients.	None identified at this stage
Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Established	Established		Patient flow group monitors definititions and expectations of this model as part of implementation.	Further developments to be undertaken in this area. Working collaboratively with regional colleagues - discharge to assess process being monitored to demonstrate appropriate approach, progress and success.	None identified at this stage

Chg 5	**Seven-day service**	Plans in place	Plans in place	Established	Established		Resilience of staff and services along with capcity and capability to maintain delivery.	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. Many Community services provide 7 day service and during current transformation more will look to provide appropriate cover based on patient need. Community services moved into 5 localities and locality teams now work 8am until 8pm to support timely discharge from hospital but also to prevent avoidable admissions. Rapid response service work 24/7 with access to urgent, intermediate, and palliative care for the unplanned interventions.	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. Collaborative system working toensure integrated provision 7 days a week. Funding needs to be identified to maintain Local Authority services seven-day service.
Chg 6	**Trusted assessors**	Established	Established	Established	Established		No major challenges as the Surge Meeting held fortnightly - increased to weekly, or called daily when needed - to address pressure is multi-agency. Focus is on enhanced co-ordinated discharge planning practices - this is operational level. Multi-partner patient flow group progressing with more strategic and development action plans.	Working relationships between Health and LA are well embedded and remain solid. With 176 referrals in the first 12 months (and a low rejection rate) the Trusted Assessor Scheme is working extremely well between Trust staff and the range enablement services. Work commenced in December 2018 to expand the Trusted Assessor model into the Trust Therapy services, with the aim being that ward based therapists will be able to directly refer to Enablement services. An established joint delivery group has identified greater integration between health and social care, and LA Provider Managers are working with Locality Teams to refine the model. The priority for 2019 is to expand the Trusted Assessor Model with the Therapy Teams and to incorporate within the Locality Services.	None identified at this stage
Chg 7	**Focus on choice**	Mature	Mature	Mature	Mature	Choice protocol is in place and understood by staff, however this has been reviewed to ensure standardisation with the Regional Policy. 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.	This requires reinforcement of the revised Regional Choice policy which is not yet signed off locally.	Local Choice Policy implemented in accordance with last version of Regional Policy, although not straightforward to embed in practice. Some issues still to be resolved e.g. when repatriating OOA. Legal team are ensuring compliance.	See 1 above.

Chg 8	**Enhancing health in care homes**	Mature	Exemplary	Exemplary	Exemplary	The monitoring/data collection continues post Vanguard and improvements not only are being sustained but enhanced when compared against other Vanguard areas and the national picture. Currently NE admission to hospital are 2% against the national figure of 11%, total number of hospital bed days per resident per year is 8% below the baseline set at the start of the programme in 2016 and for emergency bed days the current rate is -10% of the 2016 baseline.	The challenge will be continuing to sustain the front line clinical engagement and ensuring the momentum and focus of work continues. However the Community Service transformation has a focus on Care home interface with clear plans to develop the workforce across all disciplines and provides in Gatesahead challenges in funding the nurse educator posts from 2019 need to be addressed. Current provision of the model is beginning to provide equity of cover in residential homes as well as Nursing homes as a result of multi-agency collaboration.	All metrics of Vanguard programme are being met with current quarter data revealing: Currently NE admission to hospital are 2% against the national figure of 11%, total number of hospital bed days per resident per year is 8% below the baseline set at the start of the programme in 2016 and for emergency bed days the current rate is -10% of the 2016 baseline.	Nothing identied by partners.

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.									
		Q1 18/19	**Q2 18/19**	**Q3 18/19 (Current)**	**Q4 18/19 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Exemplary	Exemplary	Exemplary	Exemplary	All bags have been delivered and are becoming embedded into routine practice. Momentum maintained through Care Home Managers forums and Care Home Support Teams.	Only a small supply currently available; challenge will be in maintaining and funding stock of replacement bags.	Formal evaluation in Care Homes completed, currently seeking views of hospital teams (nursing and social care). Report due end of March 2019. Early evidence indicates care home staff value the inrtoduction of transfer of care bags as they improve relationships and therefore care.	None identified at this stage

Better Care Fund Template Q3 2018/19

5. Narrative

Selected Health and Wellbeing Board: Gateshead

Remaining Characters:	16,058

Progress against local plan for integration of health and social care

As with all BCF submissions a representative range of stakeholders are involved in the process of completing the self-assessment template, this ensures the submitted template represents as near enough as possible the operational reality of the Gateshead system / HWB area. The stakeholders include but are not limited to representatives from NGCCG, Gateshead LA and local partners.

The latest available performance data as outlined in the Non Elective Admissions, Residential Care Admissions and Reablement metrics shows we are on track against targets for the quarter as follows:.

• Non elective - Data for October if projected forward for the whole of Q3, would suggest that for the YTD April – October activity is on track to be circa 8% below plan.

• Residential admissions - latest performance (Q3) relates to April to November 2018, performance though is currently on track to meet the year end target of 854.4 per 100k (336 admissions).

• Reablement - latest performance (Q3) April to November 2018, the indicator value stands at 88.3% (454 out of 514) for all those aged 65 and over that were discharged from hospital into reablement. This is higher than at the same period last year (85.1%), and is higher than the 2018-19 target of 87.9%.

DTOC - the recent new target set for our local economy based on Q3 17/18 performance is very challenging, as this was achieved as part of an intense work programme to improve protocols in readiness for the winter period (Q3 17/18 performance represented the quarter with the lowest DTOC rate for Gateshead in 17/18).

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:	18,698

Integration success story highlight over the past quarter

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. There are already well established system working arrangements across Gateshead – not only good interagency relationships at all levels of organisations, but also great examples of joint working and innovation which have been further enhanced through good multiagency working practices.

The Old Age Psychiatry Services including current hospital in patient wards and all community services have recently moved into the Community Business Unit of GHFT.

It is anticipated that this will further improve and develop Older People services in line with the BCF initiatives.

In terms of care homes residents, the CCG continues to receive data from the national NHSE team and the latest figures continue to demonstrate that the Vanguard Care Home changes are being sustained.

Currently NE admission to hospital are 2% against the national figure of 11%, total number of hospital bed days per resident per year is 8% below the baseline set at the start of the programme in 2016 and for emergency bed days the current rate is -10% of the 2016 baseline.

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.