Better Care Fund Template Q3 2019/20

1. Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements document for 2019-20 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 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 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 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 19/20 and is not required for the current quarter Q3 19/20.

The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

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 (2. Cover)

1. This section 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.

2. 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. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

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 2019/20 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.gov.uk/government/publications/better-care-fund-planning-requirements-for-2019-to-2020

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 the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG Minimum Contribution
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

4. Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and achievements realised.

As a reminder, if the BCF plans should be referenced as below:
- Residential Admissions and Reablement: BCF metric plans were set out and collected via the BCF Planning Template
- Non Elective Admissions (NEA): The BCF metric plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions at a HWB footprint. These plans were made available to the local areas via the respective Better Care Managers and remain valid. In case a reminder of your BCF NEA plan at HWB level is helpful, please write into your Better Care Manager in the first instance or the inbox below to request them:

england.bettercaresupport@nhs.net
- Delayed Transfers of Care (DToC): The BCF metric ambitions for DToC are nationally set and remain the same as the previous year (2018/19) for 2019/20. The previous year's plans on the link below contain the DTOC ambitions for 2018/19 applicable for 2019/20:
https://www.england.nhs.uk/publication/better-care-fund-2018-19-planning-data/

This sheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, 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 and Support needs, and Achievements, 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 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.

5. HICM

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, for the reported quarter, and anticipated trajectory for the future quarter, 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

For the purposes of the BCF in 2019/20, local areas set out their plans against the model applicable since 2017/18. Please continue to make assessments against this erstwhile HICM model and any refreshed versions of the HICM will be considered in the future as applicable.

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.

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 it has been agreed to collect information on its implementation locally via The BCF quarterly reporting template as a single point of collection.
- 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: The quick guide is available on the link below:
https://www.england.nhs.uk/publication/redbag/
Further guidance is also available on the Kahootz system or on request from the NHS England Hospital to Home team through:
england.ohuc@nhs.net

6. Integration Highlights

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service/scheme or approach and the related impact.
Where this success story relates to a particular scheme type (as utilised in BCF planning) please select the scheme type to indicate that or the main scheme type where the narrative relates to multiple services/scheme types or select "Other" to describe the type of service/scheme.

Where the narrative on the integration success story relates to progressing one of the Enablers for Integrated Care, please select the main Enabler from the drop down. SCIE Logic Model for Integrated Care:
https://www.scie.org.uk/integrated-care/measuring-evaluating/logic-model

7. WP Grant

Reporting for Winter Pressures Grant is being collected alongside the BCF in a single mechanism. For this quarter, the reporting is primarily seeking narratives and confirmation on progress against the delivery of the plans set out for the Winter Pressures Grant as part of the BCF planning process.

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2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 1.1

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.

- As in previous quarters, the BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF Grant information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately.

- The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

Health and Wellbeing Board:	Gateshead
Completed by:	Hilary Bellwood and 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:	Councilor Lynne Caffrey Chair HWB 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
2. Cover	0
3. National Condition & s75	0
4. Metrics	0
5. HICM	0
6. Integration Highlights	0
7. WP Grant	0

<< Link to Guidance tab

2. Cover

	Cell Reference	**Checker**
Health & Wellbeing Board	C19	Yes
Completed by:	C21	Yes
E-mail:	C23	Yes
Contact number:	C25	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C27	Yes

Sheet Complete:	Yes

3. National Conditions

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	Cell Reference	**Checker**
1) Plans to be jointly agreed?	C9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C10	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C11	Yes
4) Managing transfers of care?	C12	Yes
1) Plans to be jointly agreed? If no please detail	D9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D10	Yes

3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D11	Yes
4) Managing transfers of care? If no please detail	D12	Yes

Sheet Complete:	Yes

4. Metrics

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	Cell Reference	Checker
Non-Elective Admissions performance target assesment	D12	Yes
Residential Admissions performance target assesment	D13	Yes
Reablement performance target assesment	D14	Yes
Delayed Transfers of Care performance target assesment	D15	Yes
Non-Elective Admissions challenges and support needs	E12	Yes
Residential Admissions challenges and support needs	E13	Yes
Reablement challenges and support needs	E14	Yes
Delayed Transfers of Care challenges and support needs	E15	Yes
Non-Elective Admissions achievements	F12	Yes
Residential Admissions achievements	F13	Yes
Reablement achievements	F14	Yes
Delayed Transfers of Care achievements	F15	Yes

Sheet Complete:	Yes

5. High Impact Change Model

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	Cell Reference	Checker
Chg 1 - Early discharge planning - Q3 19/20 (Current)	D15	Yes
Chg 2 - Systems to monitor patient flow - Q3 19/20 (Current)	D16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Q3 19/20 (Current)	D17	Yes
Chg 4 - Home first/discharge to assess - Q3 19/20 (Current)	D18	Yes
Chg 5 - Seven-day service - Q3 19/20 (Current)	D19	Yes
Chg 6 - Trusted assessors - Q3 19/20 (Current)	D20	Yes
Chg 7 - Focus on choice - Q3 19/20 (Current)	D21	Yes
Chg 8 - Enhancing health in care homes - Q3 19/20 (Current)	D22	Yes
Red Bag Scheme - Q3 19/20 (Current)	D27	Yes
Chg 1 - Early discharge planning - If Q3 19/20 mature or exemplary, Narrative	F15	Yes
Chg 2 - Systems to monitor patient flow - If Q3 19/20 mature or exemplary, Narrative	F16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - If Q3 19/20 mature or exemplary, Narrative	F17	Yes
Chg 4 - Home first/discharge to assess - If Q3 19/20 mature or exemplary, Narrative	F18	Yes
Chg 5 - Seven-day service - If Q3 19/20 mature or exemplary, Narrative	F19	Yes
Chg 6 - Trusted assessors - If Q3 19/20 mature or exemplary, Narrative	F20	Yes
Chg 7 - Focus on choice - If Q3 19/20 mature or exemplary, Narrative	F21	Yes
Chg 8 - Enhancing health in care homes - If Q3 19/20 mature or exemplary, Narrative	F22	Yes
Red Bag Scheme - If Q3 19/20 no plan in place, Narrative	F27	Yes
Chg 1 - Early discharge planning - Challenges and Support needs	G15	Yes
Chg 2 - Systems to monitor patient flow - Challenges and Support needs	G16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Challenges and Support needs	G17	Yes
Chg 4 - Home first/discharge to assess - Challenges and Support needs	G17	Yes
Chg 5 - Seven-day service - Challenges and Support needs	G18	Yes
Chg 6 - Trusted assessors - Challenges and Support needs	G19	Yes
Chg 7 - Focus on choice - Challenges and Support needs	G20	Yes
Chg 8 - Enhancing health in care homes - Challenges and Support needs	G21	Yes
Red Bag Scheme - Challenges and Support needs	G27	Yes
Chg 1 - Early discharge planning - Milestones / impact	H15	Yes
Chg 2 - Systems to monitor patient flow - Milestones / impact	H16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Milestones / impact	H17	Yes
Chg 4 - Home first/discharge to assess - Milestones / impact	H18	Yes
Chg 5 - Seven-day service - Milestones / impact	H19	Yes
Chg 6 - Trusted assessors - Milestones / impact	H20	Yes
Chg 7 - Focus on choice - Milestones / impact	H21	Yes
Chg 8 - Enhancing health in care homes - Milestones / impact	H22	Yes
Red Bag Scheme - Milestones / impact	H27	Yes

Sheet Complete:	Yes

6. Integration Highlights

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	Cell Reference	Checker
Integration success story highlight over the past quarter	B10	Yes
Main Scheme/Service type for the integration success story highlight	C13	Yes
Integration success story highlight over the past quarter, if "other" scheme	C14	Yes
Main Enabler for Integration (SCIE Integration Logic Model) for the integration success story highlight	C17	Yes
Integration success story highlight over the past quarter, if "other" integration enabler	C18	Yes

Sheet Complete:	Yes

7. Winter Pressures Grant

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	Cell Reference	Checker
Brief narrative on progress in delivering the Winter Pressures Grant spending plan	B8	Yes
Indication whether the planned spend for the Winter Pressures Grant is on track	C10	Yes
Where "NOT ON TRACK", please indicate actions being planned or in place to get back on track	C11	Yes
Have acute hospital trusts continued to be involved in the delivery of the Winter Pressure Grant plan?	C13	Yes
Please describe how this involvement is being ensured	C14	Yes

Sheet Complete:	Yes

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3. 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	

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4. Metrics

Selected Health and Wellbeing Board: Gateshead

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	Assessment of progress against the metric plan for the quarter	Challenges and any Support Needs	Achievements
NEA	Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population	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-Nov data is currently available.	Whilst the full quarter 3 data is not yet available, Apr-Nov year to date performance suggests that activity is 10% below target levels. Forecasting activity forward we would expect to remain below target by year end by 9% (target = 26,458, forecast = 23,973).
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	We have an ageing population and an increase in those with a dementia type illness. We are seeing people coming into our service later with more complex needs. Winter pressures need to be factored in at this time of year. We need to continue to support people to remain in their own homes with support services for as long as possible, however some of these services can be less cost effective than a person living in 24-hour care eg 24 hour care within a person home. We are working with our Commissioning colleagues to: •Develop a new Extra Care Scheme which will support people whose needs are complex and who have a dementia. •Review Home Care contracts to consider how people are supported in their own home.	Data is up to Nov 2019. ASCOF 2A (part 2) - 65 and over per 100,000 population = 692.87 per 100,000 population. There are 272 (compared to annual target of 348) permanent admissions which is much higher than the 205 in the same period in 2018-19 (Apr-Nov). In 2018/19 at the same point the ASCOF 2a value was 524.40 per 100,000 population therefore this year is showing a poorer performance. Underpinning the performance, during this period we had restructured the remits of some of our teams which created a waiting list for assessment of needs. This included people who were placed in short term assessment beds for further assessment. This led to a delay which in turn caused an increase in people who were then identified as requiring permanent care. Since this time, we have reviewed our team remits which has significantly reduced the
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	Continuous referrals of complex cases into PRIME. Whilst such demands have been proactively responded to by the service with great effectiveness, the service has benefitted from the use of additional staff from its In-House long-term service which is undergoing an attrition model.	Latest performance (Q3) does not cover the full 9-month period (service performance is only up to November 2019). The indicator value stands at 88.8% (619 out of 694) for all those aged 65 and over that were discharged from hospital into reablement during Jan to Jul 2019 and still at home 91 days later. This is higher than at the same period last year (88.33%) and is higher than the 2019-20 target of 87.9%. Underpinning this performance: PRIME's O.T. has swiftly assessed both the individual functioning of service users and their home environment, prescribing aids to ensure service user's continued independence within their own homes. PRIME has expanded its trusted assessor model into ward therapist to ensure the seamless absorption of step-down admissions into the service. The Rapid Response service has secured referrals from the A&E at the Q.E. Hospital, providing immediate support to stabilise service users as a precursor to PRIME

Delayed Transfers of Care	Average Number of People Delayed in a Transfer of Care per Day (daily delays)	Not on track to meet target	The new target set for our local economy is very challenging. Meeting the needs of the ageing population remains a constant challenge along with an increase in frailty and older people with a dementia. There are also recognised endemic issues within social care markets. However, despite these challenges and the challenging target the narrative from within the "system" is one of high performance (GHFT 8th highest performance in A&E in the country). On a day to day basis DTOCs is not a factor impacting on surge and operationlal performance. Issues for young people with mental health illness such as housing is a challenge which can impact on delays.	Latest Performance relates to October 2019. The average number of delays per day, per 100,000 population, is 8.31 for delays attributable to Social care and the NHS. This is outside the target of 4.0 per 100k population for Oct 2019. Performance has not changed compared to the same point for the previous year, where the equivalent rate was 8.31 per 100k population, however the targets are still based on Q3 17/18 performance which was the quarter with one of the lowest DTOC rates recorded for Gateshead. 6.35 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 (5.34). For Social care, the average number of delays per day for Oct 2019 was 1.96 per 100k. This is outside of the target of 1.3 per 100k population but performance has imporved compared to the same point for the previous

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5. High Impact Change Model

Selected Health and Wellbeing Board: Gateshead

Challenges and Support Needs — Please describe the key challenges faced by your system in the implementation of this change, and Please indicate any support that may help to facilitate or accelerate 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

			Narrative		
		Q3 19/20	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges and any Support Needs	Milestones met during the quarter / Observed impact
Chg 1	Early discharge planning	Mature	Across the Gateshead area early discharge planning is well embedded with regular reviews of the SAFER bundle continuing to be undertaken 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. Work continues to be undertaken to achieve greater standardisation of how SAFER was initially embedded and draw in latest good practice emerging.	The SAFER bundle is used in parts of the trust and the standard practices for senior reviews, board rounds and MDT working are variable from ward to ward. Particular challenges exist due to the demand for medical, nursing and therapy resource throughout all stages of the patient journey resulting in frequently having to stretch resources more and more thinly. The consequence of this being a necessary compromise between timely assessments, provision of sufficient therapeutic intervention to optimise function and availability for discharge planning. To address this challenge, a robust evaluation of the demand for services throughout all clinical pathways, benchmarking against appropriate peer organisations and an assessment of the cost effectivness of further investment would be helpful.	Acute OT service now routinely work into SSU, EAU and ED to complete assessments and identify clinical needs earlier in the patient journey. Evaluation continues however the data currently available indicates that this change has been associated with a reduced length of stay for patients requiring OT input compared to previous service model.
Chg 2	Systems to monitor patient flow	Mature	Across the Gateshead area patient flow is monitored regularly by senior clinicians throughout the day to ensure effective patient flow throughout the UEC system so that patients receive optimum care and support, with no delays. During peak demand or surges, senior clinical support is increased in line with joint local escalation plans. We now have a well established and well embedded approach to reviewing stranded patients so that they can continue their journey along the pathway of care and embedding mental health screening assessment.	The systems that were in place in 18/19 remain in situ and function well enough for the day to day running of the hospital although progress has been made with regards to the stated aim of transitioning towards a real-time digital system. A direction of travel is established for digitisation of all information related to patient flow and the trust has sufficient IT infrastructure in place to facilitate this. The limiting factor for this is engagement with clinical teams to utilise the system and input information in real-time which is essential if it is to be useful in managing patient flow. A limiting factor for this is the lack of any dedicated resource to support its implementation.	A series of pilots have been conducted to identify and troubleshoot issues with the system's functionality in specific clinical pathways (such as ward attenders, elective admissions etc) and inter-ward transfers. A dashboard has now been created to display bed availability information live on the trust's intranet homepage (although the data is not always accurate due to lack of timely data entry from ward teams).
Chg 3	Multi-disciplinary/multi-agency discharge teams	Mature	Multi Disciplinary Discharge processes are well established and embedded in Gateshead. We continue to coordinate discharge planning based on MDT/ joint assessment processes and protocols and on shared and agreed responsibilities. This has promoted effective discharge and positive outcomes for patients.	The trust's discharge team is currently uni-professional and is entirely comprised of nurses although they do liaise with other members of the multidisciplinary team on a regular basis as part of their role. As part of the NHS Improvement's 'reducing long stays' initiative each ward in the hosptial now conducts a multidisciplinary discussion regarding all patients with a LOS >6 days at least once per week. The quality and level of standardisation in these reviews, the actions taken following them and the quality of data capture remains variable between ward teams and is a work in progress.	No changes have been made to the discharge team. When the long-stay project was initially launched it was extremely successful in reducing length of stay (statistically significant difference with special cause variation) and was not associated with any increase in re-admission rate. Unfortunately, this improvement was only sustained for a period of 8 weeks so we are undertaking a review.
Chg 4	Home first/discharge to assess	Mature	Stakeholders now have a well developed and embedded multidisciplinary team and approach to assess patients holistically in the most appropriate environment and at the most appropriate time. The team is ensuring an increasing number of patients are being assessed and discharged from hospital on the same day with good links to local care homes to ensure their are no delays in discharging patients back to their home, including weekends.	The implementation of an effective discharge to assess pathway requires a culture-shift for a large number of individuals, teams and organisations with a different approach to management of risk. Progressing a complex project such as this across organisational boundaries has been difficult due to operational challenges.	A working group has been established that includes stakeholders from the health (acute and community) and from adult social care. A definition of 'discharge to assess' has been agreed upon by all stakeholders.
Chg 5	Seven-day service	Mature	Integrated 7 day MDT working practices are established and well embedded to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital as well as being discharged on a weekend when clincally appropriate or are medically fit for discharge (including restarting of care packages).	The trust continues to provide services across 7 days per week every day of the year for key services/teams and operational areas. We have highlighted an issue in respect of complex M&H assessments for weekend discharges, we are seeking to resolve this through our trusted assessor model.	Approporiate teams now provide cover over 7 days but no evidence is available to quantify the impact of this as yet.

Chg 6	**Trusted assessors**	Mature	Operational delivery of the Trusted Assessor process is now well established and embedded across health and social care, with evidence of improved outcomes and efficencies across the system. This is currenlty being rolled out across all relevant service areas. We are pleased to note that the volume of referrals by trusted assessor are equal across 7 days with single assessment processes in place.	Various trusted assessor systems are in place for different services across health and social care. Referral processes for various systems remain complex with multiple assessments required from various individuals before care can progress which can be time-consuming. We intend to have a systemic focus on simplification of access to different services, reducing duplication of assessments and forms and providing a clear focus to reduce the number of stages in a patient journey and referral procedures.	A number of trusted assessor initiatives are in various stages of implementation across health and social care with varying degrees of success and impact. A trusted assessor system exists for referrals to PRIME whereby the discharge liaison nurses complete assessments for patients on some wards and individual therapists on other wards.
Chg 7	**Focus on choice**	Mature	Choice protocol is embedded in Gateshead and understood by staff, however this has been reviewed to ensure standardisation with the Regional Policy. Planning for discharge begins on admission with EDD's set to ensure appropriate flow is maintained whilst community and social care teams work with acute teams to support people home from hospital. The Choice Policy has been implemented to challenge patients and family who previously would have had unecessary extended stays.	The policy works and has been updated after multi-agency reflection on individual cases. Further work is required to advertise the policy and ensure that all clinical staff are aware of its existence and the process as there are still occasions when it is implemented after a protracted delay.	The hospital's choice policy has been successfully launched and has been used on multiple occasions. On only one occasion has the policy had to be followed to the point of completion and a patient removed from the building and this occurred only through an extreme and unusual set of circumstances. The teamwork between health and social care in relation to this policy has been excellent.
Chg 8	**Enhancing health in care homes**	Exemplary	NGCCG as an ex care home Vanguard site has very well established high quality support, service provision and exemplary pathways of care for this group of patients - integrated with all parts of the health and care system.	Due to a high prevalance of influenza, there has been a significant number of patients requiring admission or requiring emergency care support this winter.	Scheme is already exemplary and continues to deliver outcomes

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.					
		Q3 19/20 (Current)	**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**
UEC	**Red Bag scheme**	Exemplary	NGCCG as an ex care home Vanguard site has established high quality support, service provision and exemplary pathways of care for this group of patients.	Whilst the scheme in Gateshead is embedded, the challenge is in ensuring that there are an adequate number of bags available to replenish stock out in the care homes.	Scheme is already exemplary and continues to deliver outcomes

Better Care Fund Template Q3 2019/20

6. Integration Highlight

Selected Health and Wellbeing Board: Gateshead

Remaining Characters:	18,477

Integration success story highlight over the past quarter:

Please give us an example of an integration success story observed over the past quarter. This could highlight system level collaborative approaches, collaborative services/schemes or any work to progress the enablers for integration (as per the SCIE logic model for integrated care). Please include any observed or anticipated impact in this example.

Social Care Institute for Excellence have said that effective systems leadership relies on capabilities and behaviours, and leaders in ICSs need to be skilled at:
•building strong relationships with other leaders, and often working with them informally to develop joint priorities and plans and
•establishing governance structures which drive faster change, often going where the commitment and energy is strongest
Our integration success story observed this quarter highlights examples of this in terms of system level collaborative approaches, and is linked to the enablers for integration - 2. Strong, system-wide governance and systems leadership.

The Gateshead Health & Care System is progressing integrated team working linked to its priority and transformation programme areas and BCF schemes. This includes the co-location of staff at Gateshead Place to help develop a better understanding of system challenges and opportunities to address them, as well as joining up planning and delivery arrangements with system partners. This includes:
- CCG and Council staff who have shared office space (e.g. to progress the development of an Older Persons Care Home model);

Where this example is relevant to a scheme / service type, please select the main service type alongside or a brief description if this is "Other".	
Scheme/service type	Enablers for Integration
Brief outline if "Other (or multiple schemes)"	

Where this example is relevant to progressing a particular Enabler for Integration (from the SCIE Integration Logic Model), please select the main enabler alongside.	
SCIE Enablers list	2. Strong, system-wide governance and systems leadership
Brief outline if "Other"	

Better Care Fund Template Q3 2019/20

7. Winter Pressures Grant

Selected Health and Wellbeing Board:	Gateshead

Please provide a brief narrative on progress made towards delivering the Winter Pressures Grant spending plan (as expressed within the BCF planning template 2019-20)
We have worked with system partners to maintain the levels of care packages and placements from winter 2018/19 and planned levels of spend are on track. However, we would note that this position in no way reflects the challenges and issues within the system and the risks within the Adult Social Care sector. In particular, it does not address the issue of demand outstripping funding in terms of the cost of care, including: • NLW and inflationary pressures; • the number of people needing care (the faster we discharge people, beds are filled up - so we don't see a shift from acute spend

Please indicate whether the planned spend for the Winter Pressures Grant is on track	On Track
Where "NOT ON TRACK", please indicate actions being planned or in place to get back on track	

Have local acute hospital trusts continued to be involved in delivery of the Winter Pressures Grant including any changes in the use of the grant as compared to 2018-19?	Yes
Where 'No' is selected above, please describe how this involvement is being ensured	