Better Care Fund Template Q2 2018/19

Guidance

Overview

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

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

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

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

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

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

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

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist

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

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

1. Cover

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

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

2. National Conditions & s75 Pooled Budget

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

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

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

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

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

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

4. High Impact Change Model

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

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

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

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

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

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

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

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

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

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

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

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

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
- Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
- Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.
- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:
https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx
Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

5. Narrative

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

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

6. Additional improved Better Care Fund

For 2018-19 the additional iBCF monitoring has been incorporated into the BCF form. Please fill this section in if you are responsible for the additional iBCF quarterly monitoring for your organisation, or geographic area.
To reflect this change, and to align with the BCF, data must now be entered on a HWB level.

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

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1. Cover

Version 1.0

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. ***Narrative sections of the reports will not be published.*** *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Herefordshire, County of
Completed by:	Emma Evans
E-mail:	evevans@herefordshire.gov.uk
Contact number:	01432 260460
Who signed off the report on behalf of the Health and Wellbeing Board:	Stephen Vickers

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

Complete

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

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS England

[<< Link to Guidance tab]

1. Cover

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

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget

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

Sheet Complete:	Yes

3. Metrics

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

Sheet Complete:	Yes

4. High Impact Change Model

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	Cell Reference	Checker
Chg 1 - Early discharge planning Q2 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q2 18/19	F15	Yes
Chg 5 - Seven-day service Q2 18/19	F16	Yes
Chg 6 - Trusted assessors Q2 18/19	F17	Yes
Chg 7 - Focus on choice Q2 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q2 18/19	F19	Yes
UEC - Red Bag scheme Q2 18/19	F23	Yes
Chg 1 - Early discharge planning Q3 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q3 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q3 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q3 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q3 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	H12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	H13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	H14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	H15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	H16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	H17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	H18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	H19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	H23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	I14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I17	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I18	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I19	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I23	Yes
Chg 1 - Early discharge planning Challenges	J12	Yes
Chg 2 - Systems to monitor patient flow Challenges	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J14	Yes
Chg 4 - Home first/discharge to assess Challenges	J15	Yes
Chg 5 - Seven-day service Challenges	J16	Yes
Chg 6 - Trusted assessors Challenges	J17	Yes
Chg 7 - Focus on choice Challenges	J18	Yes
Chg 8 - Enhancing health in care homes Challenges	J19	Yes
UEC - Red Bag Scheme Challenges	J23	Yes
Chg 1 - Early discharge planning Additional achievements	K12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K15	Yes
Chg 5 - Seven-day service Additional achievements	K16	Yes
Chg 6 - Trusted assessors Additional achievements	K17	Yes
Chg 7 - Focus on choice Additional achievements	K18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K19	Yes
UEC - Red Bag Scheme Additional achievements	K23	Yes
Chg 1 - Early discharge planning Support needs	L12	Yes
Chg 2 - Systems to monitor patient flow Support needs	L13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L14	Yes
Chg 4 - Home first/discharge to assess Support needs	L15	Yes
Chg 5 - Seven-day service Support needs	L16	Yes
Chg 6 - Trusted assessors Support needs	L17	Yes
Chg 7 - Focus on choice Support needs	L18	Yes
Chg 8 - Enhancing health in care homes Support needs	L19	Yes
UEC - Red Bag Scheme Support needs	L23	Yes

Sheet Complete:	Yes

5. Narrative

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

Sheet Complete:	Yes

6. iBCF

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

Sheet Complete:	Yes

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2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Herefordshire, County of

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: Herefordshire, County of

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	Achieving the NEA is challenging to partners throughout the system.	A number of key schemes continue to be delivered to assist in supporting individuals at home and avoiding admissions, where possible. Including Hospital at Home, Falls Response service and Home First.	No support needs identified
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Capacity within the care home market within Herefordshire continues to challenge partners, specifically in relation to complex nursing care provision.	Partners continue to support individuals in the community and facilitate independence, therefore reducing the rate of admissions into residential and nursing care. ASC pathway redesigned has been implemented and is delivering a strength based approach. A robust placement panel process is in place to consider and provide alternatives, where possible.	No support needs 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	The Home First service, delivered by the local authority, continue to experience recruitment challenges, which impacts upon the service capacity available. The YTD performance is currently 69.0%, against an ambition of 80%	During Q2 capacity improvements have been achieved due to the introduction of a new rota system. The service continues to develop and deliver the service review implementation plan. The new rota system went live on 1 October 2018 and we currently have the highest number of staff since the service commenced, with only 4 vacancies. The expectation is that the service will increase the number it supports from 35 to 70 by the end of October 2018.	No support needs identified

Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	Achieving the DToC target continues to pose a challenge to all partners. A number of key actions will be coming on line during Q3 but partners would welcome peer review of our plans to make sure they are robust as possible.	Partners continue to work together to deliver the HICM. Achieving progress in each of these areas will assist in improving flow throughout the system and achieving DToC reductions. A Trusted Assessor model will be implemented in Herefordshire from January 2019, an Integrated Discharge Lead post will be in place from December 2018 and D2A pathways continue to be developed.	Support to be requested from ADASS

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4. High Impact Change Model

Selected Health and Wellbeing Board: Herefordshire, County of

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

		Maturity Assessment					Narrative			
		Q4 17/18	Q1 18/19	Q2 18/19 (Current)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Plans in place	Established	Plans in place	Established	Established		Further work required to ensure that the whole system is aware of the EDD and are committed to working together to achieve.	Integrated Urgent Care Delivery Group established. This multi agency group is leading on a number of schemes, including the development and implementation of an Integrated Discharge Team. A key aim of this integrated team will be to ensure that discharge planning begins at the point of admission to the hospital.	No support needs identified
Chg 2	**Systems to monitor patient flow**	Not yet established	Plans in place	Not yet established	Plans in place	Established		DToC analysis is completed on daily basis to understand causes of delays and identify bottlenecks.	Stranded Patients reviews carried out to further inform understanding of barriers.	No support needs identified
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Plans in place	Plans in place	Established	Mature		Currently the WVT complex discharge team and ASC hospital liaison discharge team work together closely, however they are not aligned.	Partners continue to work together to implement an Integrated Discharge Team. This team will be made up of a group of professionals from both Social Care and Health who are co-located at Hereford County Hospital and collaboratively work together to ensure the safe and timely discharge of patients.	No support needs identified
Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Plans in place	Established	Mature		The Home First service, delivered by the local authority, continue to experience recruitment challenges, which impacts upon the service capacity available.	During Q2 capacity improvements have been achieved. The service continues to develop and deliver the service review implementation plan.	No support needs identified

Chg 5	**Seven-day service**	Plans in place	Plans in place	Not yet established	Plans in place	Established		Several areas of service provision are not delivered on a seven day basis e.g. community therapy services, which can often cause delays. However, seven-day services are being delivered where relevant, appropriate and demand evident.	Seven day provision continues to be delivered for key services, including Home First, Hospital at Home and Falls Response Service. Seven-day services are being delivered where relevant, appropriate and demand evident.	No support needs identified
Chg 6	**Trusted assessors**	Not yet established	Plans in place	Plans in place	Plans in place	Established		Overcoming barriers to implementation - building trust and ensuring model is right for Herefordshire.	A multi agency steering group, including care home market providers, has been established. The group is responsible for developing and implementing the Trusted Assessor model in Herefordshire.	No support needs identified
Chg 7	**Focus on choice**	Plans in place	Plans in place	Plans in place	Established	Mature		Comprehensive review of existing choice directive and processes – anticipate conclusion in coming month.	The redesigned ASC pathway continues to be delivered, which has a clear focus upon client choice and strength based assessments and voluntary sector support offer - including Community Broker	No support needs identified
Chg 8	**Enhancing health in care homes**	Plans in place	Established	Plans in place	Established	Mature		Several providers within the Care Home sector do not engage on a regular basis which can cause difficulties and delays in implementation of developments.	Clinical Professional Standards Lead continues to support care homes throughout Herefordshire with the aim to reduce admissions to hospital and improve the care standards within the care homes. Evidence of reducing admissions from care homes available.	No support needs identified

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q4 17/18	Q1 18/19	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	**Red Bag scheme**	Established	Established	Established	Established	Mature		Raising awareness of the scheme within the Acute Trust continues to be a challenge. The project team are planning a relaunch with marketing materials to address this.	A relaunch of the scheme is currently being planned and will be delivered during Q3. This is make improvements and to futher promote the scheme.	No support needs identified

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5. Narrative

Selected Health and Wellbeing Board: Herefordshire, County of

Remaining Characters:	18,884

Progress against local plan for integration of health and social care

As reported in quarter one, partners across the Health and Social care system in Herefordshire remain comitted to working together to deliver a system where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people.

Throughout quarter two partners have continued to discuss and develop integration arrangements. Further progress has been made in relation to a number of key integration work areas, including the following:

* Herefordshire's Integrated Urgent Care Model, including Integrated Hospital Discharge and Integrated Community Capacity Function - Integrated Discharge Lead post will be in place from December 2018

* Discharge to Assess (D2A) - expected to be implemented December 2018 (This may change due to negotiations with the provider)

* High Impact Change Model implementation - ongoing throughout 2018/19

* Trusted Assessor (TA) - to be implemented from January 2019 onwards

Further information is provided in the section below.

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:	18,606

Integration success story highlight over the past quarter

Herefordshire's Integrated Urgent Care Model - a multi agency delivery group has been established to lead on the implementation of a number of key schemes within this model. This includes the Integrated Discharge Team Function and Integrated Community Capacity Function.

The Integrated Discharge Team will be made up of a group of professionals from both Social Care and Health who will work together to ensure the safe and timely discharge of patients. The Integrated Discharge Team will provide a service where the main aims are:

1. That discharge planning begins at the point of admission to the hospital.
2. The outline assessment of complex patients' needs prior to discharge is undertaken
3. To provide ward staff with support, education and training regarding discharge planning of both simple and complex patient discharges.
4. To work collaboratively with community agencies such as Continuing Health Care, Therapists, Social Services and Community Matrons to ensure that patient needs have been correctly assessed and is appropriately met on discharge.
5. To ensure the development of existing discharge services and transfer of care into community settings by developing key relationships with community services.
6. To develop and produce discharge information and literature for our patients regarding the discharge process to assist them and prevent delays in their discharge.

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.

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6. Additional improved Better Care Fund

Selected Health and Wellbeing Board:	Herefordshire, County of
Additional improved Better Care Fund Allocation for 2018/19:	£ 2,496,032

These questions cover average fees paid by your local authority (including client contributions) to external care providers.

We are interested only in the average fees actually received by external care providers from local authorities for their own supported clients (including client contributions). The averages should therefore exclude:

-Any amounts that you usually include in reported fee rates but are not paid to care providers e.g. the local authorities' own staff costs in managing the commissioning of places

-Any amounts that are paid from sources other than the local authorities' funding (including client contributions), i.e. you should exclude third party top-ups, NHS Funded Nursing Care and full cost paying clients.

The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

This single average should include fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.

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

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

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

	2017/18	2018/19	If rates not yet known, please provide the estimated uplift as a percentage change between 2017/18 and 2018/19
1. Please provide the average amount that you paid to external providers for home care in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per contact hour, following the exclusions as in the instructions above)	£15.90	£16.29	
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions as in the instructions above)	£ 491	£ 518	
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions in the instructions above)	£ 681	£ 721	
4. If you would like to provide any additional commentary on the fee information provided please do so. Please do not use more than 250 characters.			