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:	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, Director of Adults and Communities

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 ^^ Link Back to top

	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 ^^ Link Back to top

	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: 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 needed identifed.
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 needed identifed.
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	YTD to the end of Dec 71.4%. This is an uplift from the end of Nov (78.6% in December alone).	The Home First service, delivered by the local authority, continue to experience recruitment challenges, which impacts upon the service capacity available however improvements have been made during Q3. Further service developments are due to be completed in Q4.	No support needed identifed.

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. An LGA DToC Peer Review is scheduled to take place during Q4.	Partners continue to work together to deliver the HICM. Key areas of development for Herefordshire currently include Trusted Assessor model, Integrated Hospital Discharge function and implementation of D2A pathways - plans for all of these areas have progressed during Q3.	Please note that an LGA DToC Peer Review is scheduled to take place during Q4.

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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

						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**	Established	Plans in place	Plans in place	Plans in place		Further work required to ensure that the whole system is aware of the EDD and are committed to working together to achieve.	The multi agency Integrated Urgent Care Delivery Group continues to lead 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.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 2	**Systems to monitor patient flow**	Plans in place	Not yet established	Plans in place	Plans in place		DToC analysis is completed on daily basis to understand causes of delays and identify bottlenecks.	Stranded Patients reviews are being carried out on a regular basis to further inform understanding of barriers. In addition an ASC Urgent Care huddle is taking place on daily basis.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Plans in place	Plans in place	Plans in place		Partners across the health and social care system work together where possible. Although teams are not necessarily co-located partners recognise the importance of aligning and working together.	The recruitment process for an Integrated Hospital Discharge manager has been completed and the post is due to commence during February 2019. MDT meetings occur across all of the community hospital sites which also includes an external provider.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 4	**Home first/discharge to assess**	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, however improvements have been made during Q3.	During Q3 further capacity improvements have been achieved. The service continues to develop and deliver the service review implementation plan.	Please note that a DToC Peer Review is scheduled to take place during Q4

Chg 5	**Seven-day service**	Plans in place	Not yet established	Plans in place	Plans in place		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 in some areas e.g. Homefirst	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.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Plans in place	Plans in place		Overcoming barriers to implementation - building trust and ensuring model is right for Herefordshire.	During Q3 the host employer for a trusted assessor post has been secured and the recruitment process for 2 FTE has commenced. Interviews are due to take place during Q4. The implementation group continue to meet to further develop the TA model for Herefordshire.	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 7	**Focus on choice**	Plans in place	Plans in place	Established	Established		Comprehensive review of existing choice directive and processes – anticipate conclusion shortly.	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	Please note that a DToC Peer Review is scheduled to take place during Q4
Chg 8	**Enhancing health in care homes**	Established	Plans in place	Plans in place	Plans in place		Several providers within the Care Home sector do not engage on a regular basis which can cause difficulties and delays in implementation of developments.	The recruitment process for the Integrated Care Home Clinical Lead has been completed and the post commenced on 2 Jan 2019. This post will lead on the alignment of the Herefordshire Council and Herefordshire CCG Quality and Compliance teams. In addition 3 clinical Care Home practioners have been recruited and will commence during Q4 and a multi-agency team will in place from Q4.	Please note that a DToC Peer Review is scheduled to take place during Q4

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**	Established	Established	Established	Mature		Providers have been taking part in the scheme however unfortunately a number Red Bags have been misplaced during the 'red bag journey' within the acute setting.	A relaunch of the Red Bag Scheme in Hereforshire was completed during Q3. This included circulation of briefings and promotional materials across a number of sites in order to promote to professionals. Literature has also been developed for clients and families/carers. Plans are in place for further awareness training with provided for Q4.	None identified.

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5. Narrative

Selected Health and Wellbeing Board: Herefordshire, County of

Remaining Characters:	18,804

Progress against local plan for integration of health and social care

As reported in previous quarters, 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 three 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 February 2019.

* Discharge to Assess (D2A) - a transition period for the pathway 3 provision has commenced. This will be fully implemented from March 2019 onwards. This pilot scheme is due to run until March 2020.

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

* Trusted Assessor (TA) - to be implemented from quarter 4 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:	19,103

Integration success story highlight over the past quarter

Integrated Community Capacity (ICC) Function

During Q3 partners have commenced more detailed discussions regarding the development of an Integrated Community Capacity Function. The integrated/aligned teams will provide daily community capacity information to inform the MDT and IDT of the availability of health and social care services in the community. The aim of the ICC will be:

- to provide timely community capacity information to the Huddle and IDT to ensure the appropriate decision is made for discharges
- to support with avoiding admissions to hospital
- to support with timely discharges from hospital
- to support with improving the length of stay

The aligning of the teams who inform the capacity and information will comprise of:

* Homefirst
* Hospital at Home
* Community Matrons
* Community occupational therapists and physiotherapists
* Community hospitals
* AWB brokers

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.