Health and Wellbeing Board

21 January 2020

BETTER CARE FUND 2019/20 QUARTER 3

1. Purpose

This report presents Quarter 3 performance regarding Walsall Better Care Fund and Improved Better Care Fund. The period covered is from October 2019 – December 2019.

2. Recommendations

2.1 That Walsall Health and Wellbeing Board receives, notes and approves the Quarter 3 return, with an opportunity to ask any questions that may arise prior to the submission deadline of 24 January 2020 to the national Better Care Fund team.

3. Report detail

3.1 The table below highlights key messages to note from the Quarter 3 Better Care Fund return. Appendix 1 details the Walsall Better Care Fund Quarter 3 return for submission, with Appendix 2 detailing the financial position.

Message to note	BCF Quarter 3 – 2019/20
Metrics	**Non - Elective Admissions (NEA)** – Emergency admissions via A&E increased by 5.3% in November 2019 compared to November 2018, and by 7.2% during the last 12 months to end of November 2019. The majority of this increase is zero day Same Day Emergency Care admissions. **Residential Admissions** – Performance over quarter 3 was in line with the target set and detailed in the 19/20 Better Care Fund plan. There is also a noted decrease in the number of admissions for November 2019, which recorded 399.07 per 100,000 population, in comparison to 428.64 per 100,000 population for November 2018. **Re-ablement** – Quarter 3 recorded an increase in the 91-day indicator for 2019 in comparison to 2018. Performance is in line with the set target following the submission of the BCF plan. **Delayed Transfers of Care** – We continue to see an increase in delays attributed to health. In line with the delayed days, performance was not in line with the agreed target.
High Impact Change Model	The 8 High Impact Change Models (Early discharge planning, Systems to monitor flow, Multi-disciplinary discharge teams, Home first/discharge to assess, Seven day working, Trusted Assessor, Choice, Enhancing health in care homes) as detailed in Appendix 1 Tab 5, are recorded as established schemes, with a few at mature status. The Red Bag Scheme has been included for quarter 3 taking the total to 9. We have seen progress across some of the models as detailed below;

	Seven Day Service – We have seen some improvement locally regarding consultant cover and therapy support in place 7 days a week across our acute setting and the community. This is a significant improvement in comparison to quarter 3 reporting for 18/19 where we were working towards implementing 7 day working across services. We will continue to monitor the progress to align it to delays recorded. Choice – We have utilised the role of our Discharge Coordinators who are part of the Intermediate Care Service to discuss pathways with patients and present a letter detailing information regarding their discharge and next steps. This should begin to support a reduction in delays regarding choice. Red Bag Scheme – We were not required to include this model within our BCF plan for 19/20, however as a local system we continue to monitor the change. The scheme is now embedded locally with development work being considered with out of area hospitals.
Income and Expenditure	Appendix 2 of the report highlights Q3 October – December 2019 forecast for Better Care Fund and Improved Better Care Fund spend. The current overall BCF position as at Q3 identifies an under spend of £209,509 due to underutilisation of CCG funded spot purchase beds. It is worth noting iBCF2 and winter funding are all showing as expected to be fully spent this financial year. In regards to winter, Walsall Adult Social Care received additional funding from central government to the total of £1.4 million, the same value received for winter 2018. The intention of the allocation is to provide councils with short term funding from November - 31 March 2020 to alleviate winter pressures on the National Health Service (NHS) by ensuring capacity in the acute setting and timely discharge. National guidance issued with the funding highlighted the following suggestions for consideration when allocating funding to areas/services within social care systems; • Managing demand pressures on the NHS • Supporting discharge from hospital • Promoting independence Walsall BCF utilised the allocation to fund additional winter capacity across re-ablement hours, bed based provision and rapid response hours. We also funded a number of short-term pilot schemes in relation to re-ablement training, block contract for community packages of care and funding weekend working.
Performance	Overall performance remains at a stable level with positive developments made across the Intermediate Care Service with evident improvements. Locally we are working on improvements across 7 day working, choice protocols and continue to see positive high levels regarding home first approach where appropriate for older people who have been discharged following a hospital admission, with assessments taking place away from the acute setting in community provision.

	Quarter 3 shows a total of 600 delayed days in October for Delayed Transfers of Care (DTOCs). The delayed days are attributed as follows; • 409 delayed days to health across equipment and patient/family choice • 191 delayed days to social care across non-acute and out of area acute hospitals • 0 delayed days to both Our delays per day target has been set at 17.9 per day. The 600 delayed days for October equate to 19 per day, exceeding the target. We have previously seen a high number of delays across Mental Health and Learning Disability hospital delays. We have utilised some of our winter allocation to fund a pilot for a MH discharge coordinator. The pilot is being monitored by the commissioning lead, with updates given to Walsall BCF Commissioning and Performance Group and A&E delivery board.

4. Health and Wellbeing Priorities

The aim of the Better Care Fund and Improved Better Care Fund is to ensure there is support through provision and enablers such as Social Workers and Therapists for those discharged from hospital returning to their own home (including residential or nursing), and to prevent a hospital admission where possible.

There are national 'ambitions' to achieve locally, ensuring there is a reduction in Delayed Transfers of Care by implementing and utilising services and schemes.

Background papers

Appendix 1 Quarter 3 BCF 2019/20 return
Appendix 2 Quarter 3 BCF financial position

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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

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
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

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

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

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

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

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
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
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will
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, cont
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

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
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
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
- 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 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 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

- 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

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

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,

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
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
Established - The initiative has been established within the HWB area but has not yet provided proven
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the
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

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

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

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

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

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

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 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 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.

Better Care Fund Template Q3 2019/20

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:	Walsall
Completed by:	Charlene Thompson
E-mail:	charlene.thompson@walsall.gov.uk

Contact number:	1922653007

Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Stephen Craddock

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

^^ Link Back to top

	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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Better Care Fund Template Q3 2019/20

3. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Walsall

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	

Better Care Fund Template Q3 2019/20

4. Metrics

Selected Health and Wellbeing Board: Walsall

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	Not on track to meet target	November 19 data for Type 1 attendance was 71.1% in comparison to 74.5% in November 18. Despite this, type 1 attendances are currently increasing at a rate of 7.5% per quarter and per 12 month period compared to the equivalent periods. This is driving the same level of increase in Non Elective Admissions i.e 8.8% in a 12 month period up to end of Nov 19. We anticipate a further rise over the Winter months	There is a slight increase in the percentage of Non Eelctive Admission's (NEA) that are Same Day Emergency Care (SDEC) admissions i.e zero day. This means that the impact in the rise in NEA's on bed day usage across in patient wards is mitigated. Our local winter planning includes the target 2 increase and the number of patients in the ambulatorary care pathway.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	The number of permanent admissions as at 30 November 2019 stands at 399.07 per 100,000 population, a decrease of -7.41% upon the 428.64 admissions as at the equivalent point in 2018. We anticipate an increase in admissions over the winter period but will manage this as a local system.	The current trend sees us remaining within our local target and continuing to perform below the agreed target. As a system we continue to see a high number of discharges home with a package of care, which enables us to contiue to meet a national and BCF aim of returning home following discharge.
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	Work continues to take place to ensure our integrated intermediate care service supports the system regarding discharges home from the acute.	171 service users were discharged from hospital into reablement/rehabilitation services during September and October 2019, of which 149 (87.13%) were still at home 91 days after discharge. This represents a 16.17% improvement on the 111 (75.00%) service users still at home out of a cohort of 148 during the equivalent period in 2018.As a winter scheme, we have funded re-ablement training for our external provider market. This support will ensure we are able to provide re-ablement across the system as well as working to develop the local provider market.

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 number of delays attributed to NHS remains higher than those attributed to social care. Provision of equipment, family choice and further non-acute NHS remain the top three reasons for NHS delays. Of the 151 social care delayed days, these sit across acute and non-acute for Walsall Manor, Dudley and Walsall Mental Health and out of borough hospitals such as the Wolverhampton, Sandwell and West Bimingham hospital groups.	600 delayed days were reported in October 2019 (of which NHS 409, Social Care 191 and Both 0), which represents a notable increase on the 485 delayed days reported in July 2019 (of which NHS 334, Social Care 151, Both 0). The 600 delayed days in October equate to 19 delayed days per day - exceeding the set target figure of 17.9 delayed days per day. Our integrated team are working closely with the acute to manage surges in discharges, utilising our winter funding to reduce LOS in step down by funding demand, additional care hours and increasing the cpapacity of our social work teams by funding weekend working.

Better Care Fund Template Q3 2019/20

5. High Impact Change Model

Selected Health and Wellbeing Board: Walsall

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**	Established		A remodel of the role of Discharge Coordinators (DISCOs) to utilise them flexibly across the system rather than being attached to wards has meant time is required to embed the change.	Length of stay targets across the medically fit list has reduced. This is in line with the changes made to the role of the DISCOs.
Chg 2	**Systems to monitor patient flow**	Established		Time to embed remodel of re-ablement officer role to have impact on flow over the winter months.	The role of the re-ablement officer was remodelled and implemented on 25 November 2019. The change now means the officers are aligned more closely with therapy and social work teams. The impact of the change should be seen through reductions in length of stay and an improved approach to assessments.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established		N/A	Assessment continue to take place away from the acute. In line with the remodel of the re-ablement officer role, officers are now aligned to MDTs and support timely discharges.
Chg 4	**Home first/discharge to assess**	Mature	Locally we continue to see a high number of discharges home with a package of care. This supports the home first agenda and works towards aims of maintaining independence and wellbeing.	Locally we have seen an increase in demand across community packages and bed capacity.	December 19 data showed a total of 221 service users across community and bed based step down services following discharges from the acute. Of the 221 users, 170 returned home with a packages of care across discharge to assess home and community re-ablement.
Chg 5	**Seven-day service**	Established		Some elements of 7 day working are still being provided on a voluntary basis.	Across the acute and community we now have weekend support from consultants and therapists. We utilised some of our winter allocation to fund overtime to drive discharges over November and December.

Chg 6	**Trusted assessors**	Plans in place		Model has changed and time to embed is required.	Different approaches are being explored locally including the use of the DISCOs or social workers as the trusted assessor.
Chg 7	**Focus on choice**	Established		Difficulties seen regarding self funders where there have been no specific discharge date	Letters are now in consistent use by the DISCOs. Letters are issued on the wards following conversations to explain the step down and discharge pathway. We will continue to monitor this model in line with DTOCs attribited against choice.
Chg 8	**Enhancing health in care homes**	Mature	The service has been in place since 2015 and has been a positive example of integration and multi-disciplinary approaches to developing and improving quality of care.	Work still continues with the 7 homes with the highest number of conveyances.	Support across residential and nursing home is now in place. Support work regarding empowerment and management will continue through the newly implemented Quality in Care team.

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**	Established		Some issues with out of area hospitals not sending bags with patients when transferring back to place of residence in Walsall.	Now established acorss residential and nursing homes. This is now linked to the newly implemented Quality in Care Team where quality assurance leads will continue to work with homes to ensure it is part of local practice.

Better Care Fund Template Q3 2019/20

6. Integration Highlight

Selected Health and Wellbeing Board: Walsall

Remaining Characters:	19,442

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.

As per the SCIE logic model, we continue to demonstrate strong, system-wide governance and systems leadership locally. We monitor and manage our integrated teams through our BCF integrated group, with escalation to our joint commissioning committee as per our agreed governance. This approach as enabled us to manage the system and out services in jointly between health and social care. This also extends to the development of our integrated care partnership, Walsall Together with key priorities in place to develop services and support across the borough.

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	Integrated Care Planning and Navigation
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	8. Pooled or aligned resources
Brief outline if "Other"	

Better Care Fund Template Q3 2019/20

7. Winter Pressures Grant

Selected Health and Wellbeing Board:	Walsall

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)
As described in our 19/20 submission, our Winter grant has been utilised to support projected demand across bed provision and re-ablement hours. We have also utilised funding to develop our provider market in line with local priorities and national aims. To date, our schemes are in place with noted support seen across the system, particularly with packages of care where additional hours have been commissioned to meet the demand. It should be noted however, there is a limited number of local providers with capacity which proves difficult for social care to respond to high levels of demand on a daily or weekly basis despite the additional investment.

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	

Walsall Healthy Partnerships Workstreams	Source of Funding	2019/20 Budget	2019/20 Budget adj	2019/20 Revised Budget	Q1 Actual	Q2 Forecast	Q3 Forecast	Q4 Forecast	Total 2019/20 Forecast	Variance before Transfer to Reserve	Transfer to Reserve	Variance after Transfer to Reserve
		£	£	£	£	£	£	£	£	£	£	£
Access to Services	CCG minimum - CCG	294,000	-	294,000	73,500	73,500	73,500	73,500	294,000	-	-	-
Subtotal Access to Services		**294,000**	**-**	**294,000**	**73,500**	**73,500**	**73,500**	**73,500**	**294,000**	**-**	**-**	**-**
Intermediate Care	CCG minimum - CCG	8,939,946	128	8,940,074	2,351,920	2,285,419	2,132,729	2,112,224	8,882,292	- 57,782	-	- 57,782
Intermediate Care	CCG minimum - LA	4,275,000	- 851,685	3,423,315	1,077,304	1,100,315	611,003	488,964	3,277,586	- 145,729	-	- 145,729
Intermediate Care	CCG additional	710,000	-	710,000	167,261	167,777	187,481	187,481	710,000	-	-	-
Intermediate Care	iBCF2	-	33,000	33,000	-	-	-	33,000	33,000	-	-	-
Intermediate Care	iBCF2 - LA Reserves	132,599	- 12,000	120,599	31,150	31,150	33,150	25,150	120,599			
Intermediate Care	Winter Funding	524,330	657,495	1,181,825	-	-	352,387	829,438	1,181,825			
Subtotal Intermediate Care		**14,581,875**	**- 173,062**	**14,408,813**	**3,627,635**	**3,584,661**	**3,316,750**	**3,676,256**	**14,205,302**	**- 203,511**	**-**	**- 203,511**
Locality Working	CCG minimum - CCG	782,000	-	782,000	191,979	198,264	199,672	192,093	782,008	8	-	8
Locality Working	CCG minimum - LA	3,539,000	879,557	4,418,557	1,111,420	1,105,080	1,094,466	1,101,695	4,412,660	- 5,897	-	- 5,897
Locality Working	iBCF1	10,308,569	-	10,308,569	2,577,142	2,577,142	2,577,142	2,577,142	10,308,569	-	-	-
Locality Working	iBCF2	988,555	- 38,254	950,301	227,193	213,389	219,843	289,876	950,301	- 0	0	-
Locality Working	iBCF2 - LA Reserves	219,716	-	219,716	92,315	100,317	16,852	10,233	219,716			
Locality Working	Winter Funding	657,495	- 657,495	-	-	-	-	-	-			
Locality Working	LA	-		-	-	-	-	-	-			
Subtotal Locality Working		**16,495,335**	**183,808**	**16,679,143**	**4,200,049**	**4,194,192**	**4,107,975**	**4,171,038**	**16,673,254**	**- 5,889**	**0**	**- 5,889**
Other	CCG minimum - CCG	1,147,000	-	1,147,000	286,750	286,750	286,750	286,750	1,147,000	-	-	-
Subtotal Other		**1,147,000**	**-**	**1,147,000**	**286,750**	**286,750**	**286,750**	**286,750**	**1,147,000**	**-**	**-**	**-**
Resilient Communities	CCG minimum - CCG	1,391,000	-	1,391,000	346,346	343,250	343,250	347,750	1,380,597	- 10,403	-	- 10,403
Resilient Communities	CCG minimum - LA	626,000	- 28,000	598,000	152,529	152,529	152,529	150,706	608,294	10,294	-	10,294
Resilient Communities	iBCF2	1,035,097	5,253	1,040,350	253,966	262,700	266,262	257,422	1,040,350	- 0		- 0
Resilient Communities	iBCF2 - LA Reserves	2,482,557	12,001	2,494,558	479,430	488,508	596,730	929,890	2,494,558			
Resilient Communities	Winter Funding	250,000	-	250,000	-	-	50,000	200,000	250,000			
Resilient Communities	LA	3,704,013	-	3,704,013	1,109,100	917,264	1,179,583	498,066	3,704,013	0	-	0
Subtotal Resilient Communities		**9,488,667**	**- 10,746**	**9,477,921**	**2,341,372**	**2,164,252**	**2,588,355**	**2,383,833**	**9,477,812**	**- 109**	**-**	**- 109**
Total BCF, iBCF1 & iBCF2		**42,006,877**	**-**	**42,006,877**	**10,529,306**	**10,303,355**	**10,373,329**	**10,591,378**	**41,797,368**	**- 209,509**	**0**	**- 209,509**