Agenda item 10

Health and Wellbeing Board

22 January 2019

BETTER CARE FUND 2018/19 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 2018 – December 2018.

2. Recommendations

2.1 That the Health and Wellbeing Board receives and notes the Quarter 3 return, and has the opportunity to ask any questions that may arise prior to the submission deadline of 25 January 2019.

3. Report detail

3.1 The table below highlights the 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 – 2018/19
Metrics	**Non - Elective Admissions (NEA)** –There is a reported decrease in 18-19 numbers compared to 17-18 based on October year to date data for emergency admissions including readmissions. Locally there has been a high number of older people over 80 years old admitted **Residential Admissions** – Performance continues to be in line with the target, with a decrease in the number of admissions for November 2018 in comparison to November 2017. **Re-ablement** – A decrease against the target is recorded and is not in line with previous performance. Data is to be reviewed in line with guidance published regarding remaining in own home after 91 days. **Delayed Transfers of Care** – Delays continue to rise for nursing and residential placements including Learning Disability and Mental Health hospitals.

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 4, are established schemes , with some mature. The additional model of Red Bag Scheme has been included, taking the total to 9. Whilst there is acknowledgment the models are established, further work is required for 3 of the models. These are detailed below; Seven Day Service – Some areas of the system are still working towards implementing 7 day working across services. Trusted Assessor – Trusted Assessors are working with providers to embed the process following implementation in October 2018. Red Bag Scheme – This is in the 'plans in place' stage for Quarter 3 with work required to implement the scheme over Quarter 4.
Income and Expenditure	Appendix 2 of the report highlights Q3 October – November 2018 forecast for Better Care Fund and Improved Better Care Fund spend. The forecast highlights an overspend on the programme for Quarter 3, however this will be rectified by utilising a proportion of winter funding in line with grant conditions from November 2018 onwards. Walsall Adult Social Care received additional funding from central government to the total of £1.4 million. The intention of the allocation is to provide councils with short term funding from November - 31 March 2019 to alleviate winter pressures on the National Health Service 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; • Home care packages to help with discharges from hospital • Re-ablement packages to support with gaining independence and carrying out everyday tasks • Home adaptations including new facilities for personal care Walsall BCF has utilised the funding to build additional winter capacity across the system and implement pilot schemes to support the system.
Performance	Overall performance is good across the programme, despite some evident improvement areas following the implementation of the new Intermediate Care Service with time required to embed new processes. The Service now has a Director in post to oversee performance and day to day running of services. As a local system, Walsall continue to ensure a 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.

	Delayed Transfers of Care continue to be an issue for the system for Quarter 3 with 840 days delayed recorded for October with specific numbers recorded for the following codes; Social Care delays • 59 days delayed for nursing placements • 77 days for residential placements • 78 days delayed for packages of care NHS delays • 206 days delayed for equipment and • 234 days delayed for family/patient choice Mental Health and Learning Disability hospital delays There continues to be inflated numbers for social care delays recorded at for Black Country Partnership Trust and Dudley and Walsall Mental Health Partnership Trust. Overall, assurance has been given by project leads to review the number of days delayed across the system. Plans are in place to implement a Commissioning and Performance group to meet monthly. The group will review services within the Better Care Fund programme and review performance with regular updates provided to Joint Commissioning Committee.
Integration	Continued work and monitoring is required to embed culture change and complete management of change successfully.

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 2018/19 return
Appendix 2 Quarter 3 BCF financial position

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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),

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

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 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

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 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

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
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)

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, 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. 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-
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

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
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
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metr
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 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
- 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

This sheet seeks a best estimate of confidence on progress against targets and the related narrative
- 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
- 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

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

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-

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 areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided prove
Mature - The initiative is well embedded within the HWB area and is meeting some of the objec
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

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

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

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 we have agreed to collect information on its
- 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 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
Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q3 2018/19

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:	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 Longhi

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

Better Care Fund Template Q3 2018/19

2. 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	

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		

Better Care Fund Template Q3 2018/19

Metrics

Selected Health and Wellbeing Board: Walsall

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	Not on track to meet target	Currently experiencing comparatively high proportion of over 80s in the local population, with warranted variation in incidence of COPD.	October data showed a decrease in year to date emergency spells, including readmissions, with 14,848 episodes recorded for 17-18 and 14,388 recorded for 18-19. Attendance avoidance schemes include Rapid Response Service; Support to Nursing Homes; HIUs project; WMAS dialling *5 for NHS 111 CAS support. Admission avoidance schemes include Ambulatory Care Pathway and Frail Elderly Service.	A&E DB Operational Group is overseeing implementation of the demand and capacity Winter Plan with support from ECIP.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Increase in admissions anticipated during the winter period.	Figures for permanent admissions have fallen from 440.4 per 100,000 population for November 2017 to 428.64 per 100,000 population in November 2018.	None at this time
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	Due to the remodelling of the Intermediate Care Service service from July 2018 onwards, the exit pathways now have a general overlap leading to a change in internal recording. Provisional figures suggest that the target has not been met for Q3; however further revisions may be necessary.	Operational integrated teams continue to work a home first pathway for older people.	None at this time

Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	There have been continued delays over October for social care, particularly for nursing placements at 59 days delayed, 77 residential days and 78 days delayed for package of care. NHS delays continued to rise in October with 206 days delayed for equipment and 234 days delayed for family/patient choice. Monitoring is required going into Winter. Across the system for both NHS and Social Care 840 days were recorded for October. 592 days against NHS, 234 for Social Care and 14 joint delays.	Over October there were 0 days delayed for housing or disputes across the system. Despite high DTOCs, the majority of older people are returning to their own home following a hospital admission. October recorded a total of 207 discharges from bed and home based provision. 163 discharges were from home based provision (64 community re-ablement and 99 DH2A)	None at this time

Better Care Fund Template Q3 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Walsall

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	Established	Established	Established		Management of Change for Discharge Coordinators is ongoing with consultation period recommensing.	During the period weekly discharges have been monitored, reducing issues with information sharing in a timely way. The use of Estimated Discharge Dates (EDD) has improved during the period.	None at this time
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established		Work is on-going to integrate health and social care systems.	EDD more consistant now which may allow Intermediate Care Service (ICS) to use tools developed to prioritise patients and support timely discharge. Dashboards are in place, enabling clear understanding of flow and performance within the system.	None at this time
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Established		Embedding new processes and new team following implementation of new integrated Intermediate Care Team.	There is an active presence on wards, through an Multi-disciplinary team (MDT) approach. ICS team working well to improve flow through and exit of ICS pathways for both bed based and home based step down provision. There have been visible performance improvements through consecutive months. Data showed 281 admissions and 277 discharges from step down re-ablement provision over November 2018, 198 admissions and 212 discharges for October , compared to 189 admissions and 198 discharges over September during quarter 2.	None at this time
Chg 4	**Home first/discharge to assess**	Established	Established	Mature	Mature	High number of older people are stepped down to home based provision following a hopsital episode, working towards home first where possible with an integrated approach to providing care.	Capacity from community reablement providers remains a concern.	A high percentage of DST assessments are now conducted in the community and not the acute setting. This has improved patient experience, and has supported flow through the acute setting as discharge to assess beds are utilised.	None at this time
Chg 5	**Seven-day service**	Established	Established	Established	Established		Still outstanding for ICS nursing staff. Cover is currently maintained on a voluntary basis. Conclusion of Management of Change for nursing staff should take place in Jan 19.	Social care staff are providing a 7 day service	None at this time

Chg 6	**Trusted assessors**	Plans in place	Established	Established	Established		Engagement between Trusted Assessor and some care providers within the borough, especially homes with D2A beds. Assurance from clincial staff that individual is medically fit for discharge is crucial to improve confidence across the system and limit risk.	The pilot commenced in October 2018. The Trusted Assessors have met with providers who have agreed to take part in the pilot, with agreement from the majority to either allow the assessors to carry out assessments on their behalf or to permit shadow assessments	None at this time
Chg 7	**Focus on choice**	Established	Established	Established	Established		Continued reported delays.	Patient choice guidance continues to be discussed at ward level with patients and family. Choice letters have been revised and are in place and used by discharge coordinators to aid discussions with patients and families.	None at this time
Chg 8	**Enhancing health in care homes**	Mature	Mature	Mature	Mature	Fully established service in place since 2015 for nursing homes which focusses on improving quality. There is an integrated appraoch in place with Multi-disciplinary meetings, community support and allocated GP support.	Lack of consistency regarding embedding culture and quality.	Full GP cover has been funded since December for 7 homes which are considered frequent flyers across the borough for a high volume of 999 calls and admissions into A&E. Support is in place through two nurses have been employed to support these homes 5 days a week, with support from rapid response 7 days a week from 8pm. Pharmaists are also supporting the homes to review medication. The pilot will end in March 2019.	None at this time

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**	Plans in place	Plans in place	Plans in place	Established		Embedding RED Bag procedures at ward level in Manor Hospital	Community Health Matron Support Team for Care Homes have been given non-recurring additional nurse capacity to purchase Red Bags and support care homes to implement the scheme. PMO support within Manor Hospital has been identified and available from end of December.	None at this time

Better Care Fund Template Q3 2018/19

5. Narrative

Selected Health and Wellbeing Board: Walsall

Remaining Characters:	19,202

Progress against local plan for integration of health and social care

New Intermediate Care Director in place to oversee operational progress of the Intermediate Care Service integrated team. There continues to be an MDT approach with staff across social care and health to facilitate discharges from the acute to and from step down provision. Provision for step down home and bed based remains in place, with re-ablement available for older people with re-ablement potential, and an overall intermediate care focus to drive discharges. There is a strong push for older people to return to their own home following a hospital episode. This is proving to be a success as the majority of discharges with a social care need return home with support where appropriate. There is a flexible model apporach in place across the Intermediate Care Service to support the system.

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:	18,951

Integration success story highlight over the past quarter

New pilot schemes have been agreed to support system over winter, but also to support the system further towards integration. Teams for Tier 1 (home and bed based discharges) and Tier 2 (home and bed based complex discharges) are still in place and working well to coordinate discharges for older people with a social care need. Intermediate care team are working on cases before they are highlighted on the Medically Fit for Discharge list. Going forward, there is the intention to see a reduction of social care cases on the list. Trusted Assessor pilot is now underway and being embedded well. Providers of bed based provision have received this well and working with the assessors. Operational winter plans are in place, with a shift of resource to meet demand where required with anticipated planning. October saw 167 home based step down placements from hopsital and 45 bed based step downs. November 222 home based and 56 bed based, December up to 7 December recorded 42 home based step down placements and 14 bed based step down placements.

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.

Walsall BCF Quarter 3 financial update

Walsall Healthy Partnerships Workstreams	Source of Funding	2018/19 Budget	2018/19 Budget adj	2018/19 Revised Budget	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Forecast	Total Forecast	Variance before Carry Forward	Net Use of Carry forward	Variance after Carry Forward
		£	£	£	£	£	£	£	£	£	£	£
Access to Services	CCG minimum - CCG	233,420	-	233,420	58,355	58,355	58,355	58,355	233,420	-	-	-
Intermediate Care	CCG minimum - CCG	8,564,216	- 6,000	8,558,216	2,011,247	2,009,838	2,090,329	2,317,655	8,429,069	- 135,147	-	- 135,147
Intermediate Care	CCG minimum - LA	4,080,810	-	4,080,810	1,248,035	948,692	1,284,999	795,501	4,277,226	196,416	-	196,416
Intermediate Care	CCG additional	1,726,957	-	1,726,957	686,177	762,588	206,802	178,576	1,834,142	107,185	-	107,185
Intermediate Care	iBCF2	287,000	-	287,000	72,325	72,327	72,327	72,328	289,306	2,306	-	2,306
Locality Working	CCG minimum - CCG	762,600	15,000	777,600	190,650	187,778	192,958	185,214	756,600	- 6,000	-	- 6,000
Locality Working	CCG minimum - LA	3,380,419	-	3,380,419	831,929	852,058	848,219	848,219	3,380,425	6	-	6
Locality Working	iBCF1	5,953,516	-	5,953,516	1,488,379	1,488,379	1,488,379	1,488,379	5,953,516	-	-	-
Locality Working	iBCF2	1,348,835	-	1,348,835	195,515	250,621	287,341	484,564	1,218,041	- 130,794	130,120	- 674
Other	CCG minimum - CCG	1,107,550	-	1,107,550	276,888	280,610	275,027	275,027	1,107,550	-	-	-
Resilient Communities	CCG minimum - CCG	1,320,093	- 9,000	1,311,093	327,773	327,773	327,773	327,773	1,311,093	- 9,000	-	- 9,000
Resilient Communities	CCG minimum - LA	598,000	-	598,000	119,676	172,041	131,955	186,422	610,093	12,093	-	12,093
Resilient Communities	iBCF2	2,447,951	-	2,447,951	672,724	631,731	605,655	905,444	2,815,554	367,603	- 367,604	- 1
Resilient Communities	LA	3,432,630	-	3,432,630	452,924	1,073,068	774,700	1,131,938	3,432,630	0	-	0
Total		**35,243,997**	**-**	**35,243,997**	**8,632,596**	**9,115,858**	**8,644,819**	**9,255,394**	**35,648,667**	**404,670**	**- 237,484**	**167,186**