Better Care Fund Template Q4 2017/18

Guidance

Overview

The Better Care Fund (BCF) quarterly monitoring template is used to ensure that Health and Wellbeing Board (HWB) areas continue to meet the requirements of the BCF over the lifetime of their plan and enable areas to provide insight on health and social integration.

The local governance mechanism for the BCF is the Health and Wellbeing Board, which should sign off the report or make appropriate arrangements to delegate this.

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 cell

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.

If required, the row heights can be adjusted to fit and view text more comfortably for the cells that require narrative information. Please note that the column widths are not flexible.

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 (hyperlinked) for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

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

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

2. National Conditions & s75 Pooled Budget

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

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

3. National Metrics

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

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

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC for the current year 2017/18 should be referenced against the agreed trajectory submitted on the separate DToC monthly collection template for 2017/18.
The progress narrative should be reported against this agreed monthly trajectory as part of the HWB's plan

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

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

4. High Impact Change Model

The BCF National Condition 4 requires areas to implement the High Impact Change Model for Managing Transfer of Care. Please identify your local system's current level of maturity for each of the eight change areas for the reported quarter and the planned / expected level of maturity for the subsequent quarters in this year.

The maturity levels utilised are the ones described in the High Impact Changes Model (link below) and an explanation for each 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

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide further detail on the initiatives implemented and related actions 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 and any impact to highlight, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

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 is currently in draft format. Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team. 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

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. However, the AEDB lens is a more representative operational lens to reflect both health and social systems. Where there are wide variations in their maturity levels, making a conservative judgment is advised. Please note these observed wide variations in the narrative section on 'Challenges'.
Also, please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making this assessment, which could be useful in informing design considerations for subsequent reporting.

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,

5. Income & Expenditure

The Better Care Fund 2017-19 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant and the minimum CCG contribution. A large proportion of areas also planned to pool additional contributions from LA and CCGs. Instead of collecting Income/Expenditure on a quarterly basis as was the case in previous years 2015/16 & 2016/17, 2017/18 requires annual reporting of Income and Expenditure at a HWB total level.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2017/18 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template. Please enter the actual income from additional CCG and LA contributions in 2017/18 in the yellow boxes provided.
- Please provide any comments that may be useful for local context for the reported actual income in 2017/18.

Expenditure section:

- Please enter the total HWB level actual BCF expenditure for 2017/18 in the yellow box provided.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2017/18.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2017-18 through a set of survey questions which are overall consistent with those from previous years.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 10 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2017/18
3. The delivery of our BCF plan in 2017/18 had a positive impact on the integration of health and social care in our locality
4. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Non-Elective Admissions
5. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Delayed Transfers of Care
6. The delivery of our BCF plan in 2017/18 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
7. The delivery of our BCF plan in 2017/18 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2017/18.
9. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2017/18?

As noted above, these are free text responses to be assigned to one of the following categories from the SCIE Integration Logic Model - Enablers summarised below. Please see link below for fuller details:
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. 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 1.1

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.

- 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:	Kerrie Allward
E-mail:	Kerrie.allward@walsall.gov.uk
Contact number:	01922 678713
Who signed off the report on behalf of the Health and Wellbeing Board:	Cllr Ian Robertson

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. Income & Expenditure	0
6. Year End Feedback	4
7. Narrative	0

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2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Walsall

Confirmation of National 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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3. Metrics

Selected Health and Well Being Board: Walsall

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
NEA	Reduction in non-elective admissions	Not on track to meet target	Nearly 30% of Type 1 attendances are referred to ambulatory pathway. The incease in zero day admissions accounts for the majority of the increase in NEA's. Work in underway to analyse ED pathway	Managed highest levels of Norovirus experienced to date. Winter funding for additional acute physician in A&E and additional A&E Consultant at weekends. Rapid response
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	N/A	2017/18 Target: 691.7. Provisional year end statement: 636.36
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	N/A	Target: 82% at home. Provisional year end statement: 82.7%
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	More robust monitoring of DTOC has been implemented which has resulted in a rise in the number of delays reported. 2018/19 performance will be reported with accurated/validated data	Target: 751.9. Provisional end of year statement not available (data not yet published)

** Your assessment of progress against the Delayed Transfer of Care target should reflect progress against the monthly trajectory submitted separately on the DToC traject*

Support Needs
ECIP on site providing support in 5 priority areas (1) ED pathways, (2) Wart Patient Flow, (3) Frailty, (4) Hospital discharge, and (5) Improvement capacity
No
No
No

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4. High Impact Change Model

Selected Health and Well Being Board: Walsall

		Maturity assessment					
		Q2 17/18	Q3 17/18	Q4 17/18 (Current)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment
Chg 1	**Early discharge planning**	Plans in place	Plans in place	Established	Established	Established	
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established	Established	
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Established	Established	Mature	Mature	
Chg 4	**Home first/discharge to assess**	Plans in place	Established	Established	Mature	Mature	
Chg 5	**Seven-day service**	Plans in place	Plans in place	Plans in place	Established	Established	
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Plans in place	Plans in place	Established	
Chg 7	**Focus on choice**	Plans in place	Plans in place	Established	Established	Established	
Chg 8	**Enhancing health in care homes**	Mature	Mature	Mature	Mature	Mature	Fully established service in place since 2015 for nursing Homes which focusses on increasing quality and reducing admissions to hopspital.

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 r

		Q2 17/18	Q3 17/18	Q4 17/18 (Planned)	Q1 18/19 (Planned)	Q2 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.
UEC	**Red Bag scheme**	Not yet established	Not yet established	Not yet established	Not yet established	Not yet established	Plans not yet established. Current arrangements are not generating issues. Plan to review arrangements in next plase of Integrated Intermediate Care

Narrative		
Challenges	**Milestones met during the quarter / Observed impact**	**Support needs**
Early discharge planning is related to ward activity and not solely ICS. Working with roles and responsiblities of Discharge Co-ordinators and supporting ESIP and Walsall Healthcare Trust in the implementation of new	concluded implementation of 0-3 of Implementaiotn of the Integrated Intermediate Care team. Phases 4-7 have commenced and the Management of Change process concludes in Qtr 2	No
DToC data sign off prior to unify ongoing live due to impact of Out of Borough hospitals submitting without sign off by Walsall Adult Social Care. Evidence of flow limited resulting in the development of a dashboard.	Dedicated dashboard monitoring patient flow and monthly monitoring now in place with data analyst in post, who ensures data validity by ongoing data cleansing. Leaflets, posters and banners now on display	No
All required elements of an Integrated Intermediate Care Service are represented in our MDT arrangements e.g. therapies, general and mental health nursing, social workers. Further work to ensure GP engagment	Full MDT arrangments functioning with Integrated Intermediate Care service reducing length of stay. We now have 6 GP led MDT's across our locality model and have recruited to a MDT coordinator to	The 6 GP led MDT's are a pilot, it this is rolled out to include the remaining 56 GP practices additional resources would be required e.g. coordinator, social worker, nurse
Volume of cases and assessment capacity in the community recently tested with 20% increase in demand due to winter pressures. Completing the staffing model through the Management of Change process. Since launch	Move to 90% of assessments now conducted outside of the acute setting. Continued with recuitment of vacant posts. CHC Nurse Assessors moved into community to conduct DST's in the community enhanced by the	No
SW, discharge coordinators and DST nursing operate on a voluntry basis. May need to consider a Management of Change process in the future	Management of change process complete for therapy staff who now provideork 7 days service	No
Two pronged approach to be taken (1) To work with Acute staff to develop ward processes that facilities accurate and timeley information to support referalls to pathways. (2) Recuitment of suitable 'external' Trusted	Work commenced with discharge co-ordinators with regards to roles and responsibilies, quality and paperwork rolling out to WHT ward staff during Qtr 1	Yes - ward staff will require significant training/ development to gain skills requird to act as a Trusted Assessor and improve quality/understand the process. Also, the streamline of paperwork and trusted
Increased numers of patients who are self funding or who exercise choice and delay discharge (including out of borough patients). Limited availability of EMI provision	WHT more frequntly implement 'Patient Choice' guidance and letters. New Integrated Intermediate Care service literature has helped manage expectations and through engagement with Discharge Coordinators	No
Limited resources to implement and embed effectively. Launched a 'Quality Summit' across partners of the system to consider the quality of care in Older People Residential homes	Develop action plan to improve Quality in care homes	Yes

residents move between care settings and hospital.		
Challenges	**Achievements / Impact**	**Support needs**
N/A	N/A	N/A

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5. Income & Expenditure

Selected Health and Wellbeing Board: Walsall

Income

	2017/18 Planned		2017/18 Actual	
Disabled Facilities Grant	£ 3,163,922		£ 3,163,922	
Improved Better Care Fund	£ 7,419,154		£ 7,419,154	
CCG Minimum Fund	£ 19,673,315		£ 19,673,315	
Minimum Subtotal		£ 30,256,390		£ 30,256,390
CCG Additional Contribution			£ -	
LA Additional Contribution			£ -	
Additional Subtotal		£ -		£ -

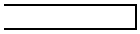
	Planned 17/18	Actual 17/18
Total BCF Pooled Fund	£ 30,256,390	£ 30,256,390

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2017/18	

Expenditure

	2017/18
Plan	£ 29,561,201
Actual	£ 28,156,203

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2017/18	The planned under spend for 2017/18 was £695k which related to iBCF2. The iBCF2 spend was reprofiled differe funding across the 3 years as per service delivery requirements and any under spends would be carried forward years The actual under spend for 2017/18 is £2.089m of which £1.905m relates to iBCF2 and will be carried forward ir



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6. Year End Feedback

Selected Health and Wellbeing Board: Walsall

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	The BCF has facilitated development of Integrated Delivery mechanisms
2. Our BCF schemes were implemented as planned in 2017/18	Agree	Although a short delay in commencement of the integrated intermediate care pathway all schemes commenced as planned during 2007/18
3. The delivery of our BCF plan in 2017/18 had a positive impact on the integration of health and social care in our locality	Agree	We have a truly integrated intermediate care service (not just co-located) and are developing our integrated locality teams well.
4. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Non-Elective Admissions	Disagree	The BCF plan 2017/18 has not had a positive impact in reducing overall on non elective admissions although it is anticipated that without the planned services non-elective admissions would have been higher.
5. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	Although our DToC figures were reviewed during 2017/18 we now have robust systems in place with a dedicated resource to build on for 2018/19
6. The delivery of our BCF plan in 2017/18 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Strongly Agree	We have embedded MDT arrangmeents with a strong emphasis on reablement/rehabilitation demonstrated by our performance exceeding target
7. The delivery of our BCF plan in 2017/18 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	With an emphasis on reablement/rehabilitations, wider access to providers and robust support planning we are able to facilitate safe discharge back to the community where appropriate. However, the efforts in Intermediate Care are being deliberately offset by planned moves to residential care where this is appropriate in long term care settings.

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and three Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **successes**
Success 1	2. Strong, system-wide governance and systems leadership	The Walsall Together Board is a well represented and ambitous forum for leaders across the Health & Social Care system (inc Vol Sector) work together on system improvement plans.
Success 2	8. Pooled or aligned resources	Launch of our Integrated Intermediate Care service during 2017/18 led by a Director (appointed by Adult Social Care) mananing staff employed by the healthcare trust and the council across different professional disciplines. The budget for which was a pooled commissioning budget within the Better Care Fund.

8. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **challenges**
Challenge 1	6. Good quality and sustainable provider market that can meet demand	Limited EMI provision and poor quality / provider failure is a real risk for Walsall. During 2017/18 we have managed the impact of care home closures (following CQC intervention), novation of domicillary care contracts and provider ownership changing e.g. BUPA
Challenge 2	9. Joint commissioning of health and social care	Although our formal Joint Commissionging arrangements ceased Walsall Council continues to commission a range of services on behalf of Walsall Clinical Commissioning Group including nursing care home placements, rapid response and dementia services. Discussions are ongoing to establish a strong foundation for integrated commissioning going forward

Footnotes:

Question 8 and 9 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

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7. Narrative

Selected Health and Wellbeing Board: Walsall

Remaining Characters:	15,435

Progress against local plan for integration of health and social care

1. Training and education work stream
Purpose: Develop training and educational material to communicate 'what, when, how, and why' to Patients and Trust staff re Care Act obligations, ICS Pathways etc. The materials will aid decision-making re post-discharge services, clarify process and responsibilities of Ward staff and ICS staff. Additionally the information will assist in managing patients / carers expectations.
Progress: Leaflets / posters and process guides are in use and being embedded at ward level, with training to ICS staff being delivered from January 2018. Training will be offered to Trust ward staff post winter pressures, April on ward and linked with the work of ECIP in terms of process and quality practice.
2. Increase percentage of assessments to community setting
Purpose: Facilitate an increase in timely assessments outside of the acute setting and maximise use of ICS community infrastructure.
Progress: Mechanisms to schedule Social Care assessments in community setting implemented.
Outcome – the service has moved from 30% of ASC assessments being conducted in a community setting to 90%.
3. Perform Continuing Health Care Decision Support Tools (CHC DST's) in community setting
Purpose: Patients discharged via DH2A and D2A pathways transfer to have DST performed in a community setting.
Progress: The proposed change was implemented during February 2018. The service has moved from a position of 0% assessments conducted in the

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:	18,813

Integration success story highlight over the past quarter

A full suite of outcome measures has now been developed for our Integrated Intermediate Care service. One of the key functions of the ICS model is a reduction in the number and length of stay of patients on the Medically Fit for Discharge (MFFD) list. During period Oct to Dec there was an average of 110 people per day, with an average of 11 days length of stay (LOS) on the MFFD list. The target was to achieve an average of 80 with 6.5 days LoS by March 2018. This creates additional capacity in inpatient beds that will reduce delays of patients awaiting admission to an inpatient ward. Since implementation the average number of people on the MFFD list per day has decreased from 110 in October to 101 in December 2017 with an average LOS on the list of 11 days in October reducing to 10 in December. In Qrt 4 bed days lost has reduced from 1047 in January, 1003 in February to 857 in March. Over the last three months the average numbers on the MFFD are 90 with an average LOS of 8.41 days. This performance should be set in the context of an 18% increase in admissions to the list and a 50% increase in those that are deemed 'Not Medically Fit' at the point of ICS Team review.

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.

Better Care Fund Template Q4 2017/18

Checklist

<< Link to Guidance tab

Complete Template

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

	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? If no please 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

	Cell Reference	Checker
NEA Target performance	D7	Yes
Res Admissions Target performance	D8	Yes
Reablement Target performance	D9	Yes
DToC Target performance	D10	Yes
NEA Challenges	E7	Yes
Res Admissions Challenges	E8	Yes
Reablement Challenges	E9	Yes
DToC Challenges	E10	Yes
NEA Achievements	F7	Yes
Res Admissions Achievements	F8	Yes
Reablement Achievements	F9	Yes
DToC Achievements	F10	Yes
NEA Support Needs	G7	Yes
Res Admissions Support Needs	G8	Yes
Reablement Support Needs	G9	Yes
DToC Support Needs	G10	Yes

Sheet Complete:	Yes

4. HICM

	Cell Reference	Checker
Chg 1 - Early discharge planning Q4	H8	Yes
Chg 2 - Systems to monitor patient flow Q4	H9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4	H10	Yes
Chg 4 - Home first/discharge to assess Q4	H11	Yes
Chg 5 - Seven-day service Q4	H12	Yes
Chg 6 - Trusted assessors Q4	H13	Yes
Chg 7 - Focus on choice Q4	H14	Yes
Chg 8 - Enhancing health in care homes Q4	H15	Yes
UEC - Red Bag scheme Q4	H19	Yes
Chg 1 - Early discharge planning Q1 18/19 Plan	I8	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19 Plan	I9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19 Plan	I10	Yes
Chg 4 - Home first/discharge to assess Q1 18/19 Plan	I11	Yes
Chg 5 - Seven-day service Q1 18/19 Plan	I12	Yes
Chg 6 - Trusted assessors Q1 18/19 Plan	I13	Yes
Chg 7 - Focus on choice Q1 18/19 Plan	I14	Yes
Chg 8 - Enhancing health in care homes Q1 18/19 Plan	I15	Yes
UEC - Red Bag scheme Q1 18/19 Plan	I19	Yes
Chg 1 - Early discharge planning Q2 18/19 Plan	J8	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19 Plan	J9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19 Plan	J10	Yes
Chg 4 - Home first/discharge to assess Q2 18/19 Plan	J11	Yes
Chg 5 - Seven-day service Q2 18/19 Plan	J12	Yes
Chg 6 - Trusted assessors Q2 18/19 Plan	J13	Yes
Chg 7 - Focus on choice Q2 18/19 Plan	J14	Yes
Chg 8 - Enhancing health in care homes Q2 18/19 Plan	J15	Yes
UEC - Red Bag scheme Q2 18/19 Plan	J19	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	K8	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	K9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain	K10	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	K11	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	K12	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	K13	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	K14	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	K15	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	K19	Yes
Chg 1 - Early discharge planning Challenges	L8	Yes
Chg 2 - Systems to monitor patient flow Challenges	L9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	L10	Yes
Chg 4 - Home first/discharge to assess Challenges	L11	Yes
Chg 5 - Seven-day service Challenges	L12	Yes
Chg 6 - Trusted assessors Challenges	L13	Yes
Chg 7 - Focus on choice Challenges	L14	Yes
Chg 8 - Enhancing health in care homes Challenges	L15	Yes
UEC - Red Bag Scheme Challenges	L19	Yes
Chg 1 - Early discharge planning Additional achievements	M8	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	M9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	M10	Yes
Chg 4 - Home first/discharge to assess Additional achievements	M11	Yes
Chg 5 - Seven-day service Additional achievements	M12	Yes
Chg 6 - Trusted assessors Additional achievements	M13	Yes
Chg 7 - Focus on choice Additional achievements	M14	Yes
Chg 8 - Enhancing health in care homes Additional achievements	M15	Yes
UEC - Red Bag Scheme Additional achievements	M19	Yes
Chg 1 - Early discharge planning Support needs	N8	Yes
Chg 2 - Systems to monitor patient flow Support needs	N9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	N10	Yes
Chg 4 - Home first/discharge to assess Support needs	N11	Yes
Chg 5 - Seven-day service Support needs	N12	Yes
Chg 6 - Trusted assessors Support needs	N13	Yes
Chg 7 - Focus on choice Support needs	N14	Yes
Chg 8 - Enhancing health in care homes Support needs	N15	Yes
UEC - Red Bag Scheme Support needs	N19	Yes

Sheet Complete:	Yes

5. Income & Expenditure

	Cell Reference	Checker
2017/18 - Actual CCG additional contribution income	G14	Yes
2017/18 - Actual LA additional contribution income	G15	Yes
2017/18 - Difference between plan & actual income Commentary	E21	Yes
2017/18 - Actual Spend	D31	Yes
2017/18 - Difference between plan & actual expenditure Commentary	E33	Yes

Sheet Complete:	Yes

6. Year End Feedback

	Cell Reference	Checker
Statement 1 - Joint working Delivery Response	C10	Yes
Statement 2 - BCF Scheme Delivery Response	C11	Yes
Statement 3 - Health & Social Care Integration Delivery Response	C12	Yes
Statement 4 - NEA Delivery Response	C13	Yes
Statement 5 - DTOC Delivery Response	C14	Yes
Statement 6 - Reablement Delivery Response	C15	Yes
Statement 7 - Residential Admissions Delivery Response	C16	Yes
Statement 1 - Joint working Delivery Commentary	D10	Yes
Statement 2 - BCF Scheme Delivery Commentary	D11	Yes
Statement 3 - Health & Social Care Integration Delivery Commentary	D12	Yes
Statement 4 - NEA Delivery Commentary	D13	Yes
Statement 5 - DTOC Delivery Commentary	D14	Yes
Statement 6 - Reablement Delivery Commentary	D15	Yes
Statement 7 - Residential Admissions Delivery Commentary	D16	Yes
Success 1 category	C22	Yes
Success 2 category	C23	Yes
Success 1 response	D22	Yes
Success 2 response	D23	Yes
Challenge 1 category	C27	Yes
Challenge 2 category	C28	Yes
Challenge 1 response	D27	Yes
Challenge 2 response	D28	Yes

Sheet Complete:	Yes

7. Narrative

	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