HEALTH AND WELLBEING BOARD

THURSDAY 23rd NOVEMBER 2017

SUPPLEMENTARY PACK

AGENDA ITEM 12 - For Information – iBCF (Spring Budget) and Better Care Fund 2017/18 Quarter 2 Returns.

Appendix 2 to the report is now attached

Agenda complied by: Helen Gray
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Appendix 2 - BCF Q2 2017/18 Performance Return

Better Care Fund Template Q2 2017/18

1. Cover

Version 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.
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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

Better Care Fund Template Q2 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Leeds

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		

Better Care Fund Template Q2 2017/18

3. Metrics

Selected Health and Well Being Board: Leeds

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	Whilst activity is lower than our plan for the year the length of stay of those patients admitted is generally longer	NEA is below plan	None
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	An increased focus upon transfering people from hospital may increase demand on services to support people to regain independence and lead to increased demand for care home placements.	The projected figures show that we will meet the target. Work is ongoing to increase capacity across the city in the provision of CIC beds to support transfers of care rather than people being admitted to permanent care home placements.	None
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	This measure relates to the proportion of people who are still at home 91 days after being discharged from hospital and the target is 90%. There is a balance to be made between a high level of performance and allowing people the opportunity of being supported to return home, when it may turn out that they are in fact not able to manage at home.	ASC reablement services have been restructured to provide more capacity	None
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	Increases in DTOCS reported within the Leeds Mental Health Provider. This has risen from average of 12 in Q4 last winter to 37 in late october	Agreement to a number of initiatives to support flow through iBCF. Implemnation of Community Beds Strategy	None

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

Better Care Fund Template Q2 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Leeds

		Maturity assessment			Narrative			
		Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (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	Mature		Size of hospital and challenge of ensuring consistent approach across all admission routes and wards across two sites	Closer working between integrated Discharge Service and Hospital Social Work Teams to improve discharge planning. Ongoing work to improve assessment prior to admission through implementation of new frailty unit. Discharge planning for frail elderly patient will begin prior to admission	None
Chg 2	**Systems to monitor patient flow**	Plans in place	Established	Established		Ensuring routine/daily flows of demand data to support whole system responses to fluctuations in demand. Agreement to establish DTOC monitoring arrangements to all bed holiding providers e.g. Mental Helath and Community Beds to ensure flow maintained	Establishment of agreed daily system flow reporting by all NHS providers. Agreed Mutual Aid and Escalation Policy across all NHS Providers.	None
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established		Expansion from current limited service (Operating in A&E, Assessment and Medical and elderly Wards only) to whole hospital	Agreement to funding increased capacity. Agreement to review current model with aim to commission whole systems model in readiness for winter 2018/19	None
Chg 4	**Home first/discharge to assess**	Established	Established	Mature		Large number of care home providers offering different approaches to trusted assesment and variable response times with regards to assessment within reasonable timeframe	Increased capacity within reablement to support success of aproach. Establishment of new community bed strategy which embeds Transfer to Assess Protocols	None
Chg 5	**Seven-day service**	Not yet established	Not yet established	Not yet established		Equipment Services are operating on a 7 day basis and iBCF monies have been prioritised for Rapid Response Social Workers to maintain a 7 day service during this coming winter.	Beginning to review feasibility of changing to 7 day working for services where there is interdependence between health and social care and changes in behaviour required to realise benefits	None

Chg 6	**Trusted assessors**	Established	Established	Mature		Further work is required to understand options for Trusted Assessment for readmission to existing care homes. Main challenges associated with Trusted Assessment by Care Homes. We are working with Care Homes to improve response times for assessment	One assessment format agreed between organisations/professions. iBCF approval to increase Trusted Assessor capacity to extend across all Leeds Teaching Hospital Locations (recruitment underway)	None
Chg 7	**Focus on choice**	Mature	Mature	Mature	Integrated Discharge Service work with Age UK to support patients choose care homes. Intergrated Discharge Service work proactively with Patients and Families to ensure they are aware on need to ensurep they are planning for out of hospital provision in readiness for discharge. Weekly meetings to review all patients where difficulties being experienced in securing placement	Lack of provission for patients with complex needs notably elederly with complex mental health issues associated with dementia	Dementia Board Workshop to progress need for solution to issue associated with difficulties in out of hospital provision fro dementia patients. Proposals to be developed in current quarter	None
Chg 8	**Enhancing health in care homes**	Established	Established	Mature		See issue re dementia above	Number of schemes in place in Leeds. A review is being undertaken to align three Leeds CCG funded care home schemes ensuring best practice of each embedded in new scheme to be procured over coming year.	None

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.								
		Q2 17/18 (Current)	**Q3 17/18 (Planned)**	**Q4 17/18 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Established	Established	Established		The red bags are not always sent from the actue setting at the same time as the patient	Care Homes have responded well to this scheme	None

Better Care Fund Template Q2 2017/18

5. Narrative

Selected Health and Wellbeing Board: Leeds

Remaining Characters:	18,927

Progress against local plan for integration of health and social care

As articulated in the Leeds 2017-19 BCF Narrative Plan, the Leeds BCF is a contributor to the delivery of the Leeds Health and Care Plan (which in turn forms a strand of the Leeds Health & Well-being Strategy). The Leeds Plan is founded on the development of a Population Health Management approach for the city and in quarter 2, partners have been involved in a series of workshops and have identified the population segments that will be focussed on initially (frailty and end of life) with the intention of starting phase 1 implementation in 2018/19.

Our 13 neighbourhood teams continue to work in partnership with other organisations wrapping care around the patient. Each neighbourhood in Leeds is aligned to a Community Geriatrician and integrated neighbourhood team who work with our primary care teams as part of a wider MDT. These teams are providing a greater focus on preventative care and self-management, reducing hospital admissions. Often teams are required to prioritise their caseload to support system flow and respond to urgent and rapid requests.

Remaining Characters:	18,521

Integration success story highlight over the past quarter

A significant area of success in our plan is in respect of implementing a new Community Bed strategy across Leeds. Contracts were awarded for a new Community Care Beds Service (CCBS) in September 2017 following a procurement process led by the Leeds CCGs Partnership with a mobilisation date of 1st November 2017 in readiness for Winter. Capacity has increased to 227 beds across seven bed bases and will cater for both Intermediate Care and a new Transfer To Assess model. The service has been commissioned to provide personalised, proactive care and reablement and rehabilitation and is supported by local general practitioners to provide enhanced cover to beds, community geriatricians and our 13 neighbourhood teams. The CCBS mobilised on time and has been operational since 1st November 2017. In the first week, 35 patients were admitted to CCBS beds.

The pathway will be delivered through an integrated approach between Leeds Teaching Hospitals Trust, Leeds Community Healthcare Trust, the Local Authority and the independent sector. The service will now include capacity for hospital 'discharge to assess' patients as well as people requiring active rehabilitation, so that people's longer term care needs can be assessed outside of the hospital environment and reduce delayed transfers of care. The new Community Care Beds Service is grounded within the established integrated Neighbourhood Teams model to ensure smooth transfer for those who are returning home.

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