Better Care Fund Template Q4 2017/18

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.

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- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

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Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Rebecca Charlwood

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: 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		

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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	Activity remains that contained in the CCG operational plan and is below last years' activity levels as a result of increased focus of admission avoidance. However pressure on the acute sector remains high due to increasing Lengths of Stay	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 transferring 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	The number of DTOCs is starting to reduce in both the acute and mental health trust. The Acute Trust is now below 3.5% of its bed base being occupied by DTOCs	Agreement of a number of initiatives to support flow throuh iBCF. Implementation of Community Beds strategy. Also review of options for provision of out of hospital care for patients with complex behaviour as a result of dementia	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*

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4. High Impact Change Model

Selected Health and Well Being Board: Leeds

		Maturity assessment					Narrative			
		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	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Established	Established	Mature	Mature		Size of hospital and challenge of ensuring consistent approach across all admission routes and wards across two sites	Ongoing process to improve discharge planning	None
Chg 2	**Systems to monitor patient flow**	Plans in place	Plans in place	Established	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 holding providers e.g. Mental Health 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	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 for capacity. Agreement to review current model with aim to commission new whole systems model in readiness for Winter 2018/19	None
Chg 4	**Home first/discharge to assess**	Established	Established	Established	Mature	Mature		Large number of care home providers offering different approaches to trusted assessment and variable response times with regards to assessment within reasonable timeframe	Looking to explore increased scope for reablement following success in approach to date. New community bed capacity now in place. MADE event identified a need for increased focus on transfer/discharge to assess pathways	None
Chg 5	**Seven-day service**	Not yet established	Not yet established	Not yet established	Not yet established	Not yet established		Equipment Service is 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	Established	Mature	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	Continuing recruitment to iBCF funded Trusted Assessor capacity. This will extend trusted assessment to all base wards at Leeds Teaching Hospitals Trust	None

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Chg 7	**Focus on choice**	Mature	Mature	Mature	Mature	Mature	Progress is being made on developing options for the commissioning of dementia care. It is estimated that up to 30 delayed transfers of care are associated with difficulties in providing care home placements for patients with dementia, many of whom are coded under the 'choice' category. Age UK are commissioned to support patients and their carers in viewing and selecting care homes	Lack of provision for patients with complex needs notably elderly with complex mental health issues associated with dementia	Significant workstream established to indentify capacity solution to meet needs of dementia patients. Options include enhancing support and funding to care homes, development of bespoke step down unit	None
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Mature	Mature		See issue re dementia above	CCG is looking to appoint care home lead to support development of sector. Work is underway to review capacity in Mental Health community services with a scheme being developed aimed at offering support to care homes for patients with dementia	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	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.	Challenges	Achievements / Impact	Support needs
UEC	**Red Bag scheme**	Established	Established	Established	Established	Established		The red bags are not always sent from the acute setting at the same time as the patient	Care Homes have responded well to this scheme	None

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5. Income & Expenditure

Selected Health and Wellbeing Board: Leeds

Income

	2017/18 Planned		2017/18 Actual	
Disabled Facilities Grant	£ 6,199,289		£ 6,199,289	
Improved Better Care Fund	£ 16,188,622		£ 16,188,622	
CCG Minimum Fund	£ 51,228,544		£ 51,228,544	
Minimum Subtotal		£ 73,616,455		£ 73,616,455
CCG Additional Contribution			£ -	
LA Additional Contribution	£ 2,877,333		£ 2,877,334	
Additional Subtotal		£ 2,877,333		£ 2,877,334

	Planned 17/18	Actual 17/18
Total BCF Pooled Fund	£ 76,493,789	£ 76,493,789

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

Expenditure

	2017/18
Plan	£ 76,493,789
Actual	£ 76,493,789

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	

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6. Year End Feedback

Selected Health and Wellbeing Board: Leeds

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	There was already a well established, strong relationship between health and social care in Leeds. The BCF has added a bit more focus to this relationship but has also brought with it additional bureaucracy.
2. Our BCF schemes were implemented as planned in 2017/18	Agree	Our schemes have been implemented as planned.
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	Disagree	There was already a well established health and wellbeing structure in place before BCF and more confusion has now been created with a multiplicity of plans including BCF, A&E plan, WY and Harrogate STP and our own Leeds Plan.
4. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Non-Elective Admissions	Agree	The BCF process has prompted more focus onto NEAs and the number of NEAs is below plan.
5. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	The BCF process has prompted more focus onto DToCs and the number of DToCs is starting to reduce in both the Acute and Mental Health Trusts. The Spring Budget monies have also helped Adult Social Care related DToCs keep consistently under target.
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	Agree	Adult Social Care reablement services have been restructured to provide more capacity.
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	Leeds implemented a new Community Care Bed Strategy in 2017-18 to support transfers of care rather than people being admitted to permanent care home placements.

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.

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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	3. Integrated electronic records and sharing across the system with service users	The Leeds Care Record. This is a joined-up digital care record which enables clinical and care staff to view real-time health and care information across care providers and between different systems. It is a secure computer system that brings together certain important information about patients who have used services provided by their GP, at a local hospital, community healthcare, social services or mental health teams.
Success 2	6. Good quality and sustainable provider market that can meet demand	The Community Care Bed Strategy. Leeds implemented a new Community Care Bed strategy during 2017-18. Following a re-procurement exercise, the new Community Care Bed Service became operational on 1st November 2017. 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 pathway into the Community Bed Care Service is being 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.

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	Other	Reducing delayed transfers of care. Increases in delayed transfers of care have been reported within the Leeds Mental Health provider with most of these DToCs being dementia related. A Dementia Board Workshop has been held to look at the issues and difficulties in out of hospital provision for dementia patients. A number of initiatives have been agreed, funded by monies from the iBCF grant/spring budget to support system flow.
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Ongoing lack of nursing staff.

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

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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

Other

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7. Narrative

Selected Health and Wellbeing Board: Leeds

Remaining Characters:	18,487

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 all partners have been involved in a series of workshops which has identified the population segments that will be focussed on initially (frailty and end of life.) The new Frailty Unit has been established at LTHT which operates with resources from across health and social care agencies including 3rd sector. It integrates assessment and discharge planning by utilising the skills of staff from LTHT, LCH, Adult Social Care and 3rd sector. Partners are working together to support the commissioning and development of community provision for patients with dementia. This will require agreement to joint commissioning of both clinical teams and independent sector provision.

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.

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:	18,899

Integration success story highlight over the past quarter

We have now completed the implementation of the 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 in readiness for Winter. Capacity is now at 227 beds across seven bed bases catering for both Intermediate Care and a new Transfer To Assess model. Despite a challenging winter and initial start up issues associated with implementing a new model we are now beginning to develop a better undertsanding of how to manage flow through our community beds. As such we have seen a gradual reduction in delays for patients waiting in hospital for community beds. We have also seen few delays associated with patients requiring community care.

We are now undertaking further work following on from the NHS Improvement led MADE event to further develop our approach to 'discharge to assess' to enable increasing number of patients longer term care needs to be assessed outside of the hospital environment and as such reduce long stays and delayed transfers of care.

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.

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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

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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

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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