Appendix 1 - BCF Q3 2018/19 Return

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 ***Narrative sections of the reports will not be published.*** *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information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:	Leeds
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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. Narrative	0

[<< 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

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	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

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	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

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2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Leeds

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		

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Metrics

Selected Health and Wellbeing Board: Leeds

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	On track to meet target	None	Growth in non-elective admissions has remained below national averages for a number of years and below planning assumptions issued by NHSE	None
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	None	Residential admissions per 100,000 over 65's – 580 (2017/18: 608). Compared to the same period last year permanent admissions to care homes from hospital have halved from around 160 to 80. In addition admissions to temporary placements for short term rehabilitation have increased, in particular placements to nursing homes and for those with dementia.	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	At the same time last year the figures suggested just 72% at home based upon available data and the end year result was 85%. A related measure includes the percentage who are independent at the end of reablement and the figure here has increased from 59% in 2017/18 to 65% being independent this year to date.	Percentage over 65s at home after 91 days – 77% (2017/18: 85%). The proportion of over 65's supported from hospital by short term reablement services in the community have increased significantly this year.	None

Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	DTOCS at LYPFT / Mental Health remain a challenge. Key areas that require addressing include a) DTOCS for patients on acute psych wards and b) patients with dementia	DTOCs in main acute provider have continued to reduce down to 34 in December from 55 in October. As such numbers in LTHT remain below 3.5% of bed base . A number of initiatives are underway to try and address delays in MH including • Established process for individuals who are over 65 i.e. The Mount DToC list is distributed on a Monday, operational multi-agency meeting to work on progress every Wednesday, verification of codes every Thursday. • Fortnightly capacity meetings are held chaired by the LYPFT deputy chief operating officer • Weekly performance reports shared across organisations. • Implementation of Section 117 Panel	• Additional finance in place to fund a transitional period of up to 6 weeks. • Establishment of Care Navigator post to oversee transfers of care. • Dedicated ASC Team Manager focusing upon this.

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4. High Impact Change Model

Selected Health and Wellbeing Board: Leeds

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	Mature	Transfer of Care Protocol has now been agreed which includes early discharge planning. This is supported by the implementation of the SAFER bundle	Organisational Development to implement new TOC Policy	Full work programme supporting the delivery of the SAFER bundle. System wide agreement of a Transfer of care protocol, implementation in progress across LTHT	None
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Mature	The Newton Europe work identified the need to address discharge destinations for patients which were suboptimal. The system has etsablished a working group that will undertake ongoing review of system flows	Defining effective monitoring mechanisms/metrics that support systems undertanding of capacity gaps in community settings	Full action plan in place building on the Newton Europe findings - all work streams are developing key metrics that are mapped to the high level metrics of the A&E Delivery Board	None
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Mature	Mature	System has implemented the Leeds Integrated Discharge Service that works alongside A&E ward staff to support admission avoidance and discharge of complex patients	Understanding impact of shift to transfer to assess models on multiagency discharge service	Appointment of senior officer in LTHT to lead on development of flows out of hospital, to further support the development of the discharge pathways and the Leeds Integrated Discharge Team.	None
Chg 4	**Home first/discharge to assess**	Established	Established	Established	Established	The Leeds system has developed and signed off a Home First Policy. The principles of Home First and Discharge to Assess are being implemented through development of a range of out of hospital services including reablement and community beds	Building capacity to support D2A	A multi-agency workstream has developed key principles and an easy to reference chart which supports the decision making on the wards. Increase in social work attendance at Ward Rounds, increase in Case Officers to support access to reablement. Reduction in delays seen as a result.	None
Chg 5	**Seven-day service**	Not yet established	Not yet established	Not yet established	Not yet established		As previously reported	As previously reported	None
Chg 6	**Trusted assessors**	Established	Established	Mature	Mature	Trusted assessorsin place across the system including access to equipment and same day access to reablement , establshed across multi-agency pathways. Leeds is now developing Trusted Assessors for care homes, once the peson has been assessed as requiring a residential/nursing placement.	Building care home trust in assessment of newly agreed Care Home Trsuted Assessors	Job Description has been agreed and funding established . Leeds Care Homes Association wil recruit, emply and support two trusted assessor roles.	None
Chg 7	**Focus on choice**	Mature	Mature	Mature	Mature	New Transfer of Care Policy Developed and now being implemented in LTHT, system seeking to propogate the policy to other providers such as LYPFT and in communty beds	None	Implementation of TOC Policy at LTH continues to address high numbers of patients delayed within the choice category	None

Chg 8	**Enhancing health in care homes**	Established	Established	Established	Established		Need to develop care home sector capability to meet needs of increasingly complex and frail patients	Full care home action plan in place covering quality improvments, improving medical support and admission avoidance.	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.									
		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**	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. Narrative

Selected Health and Wellbeing Board: Leeds

Remaining Characters:	19,248

Progress against local plan for integration of health and social care

The foundation to Leeds' integrated system is the well-established integrated neighbourhood team service. These are forming the basis of the development of Local Care Partnerships which will extend the membership of the local integrated teams to a wider range of partners while remaining focused on place. Significant work is being undertaken to agree how the findings of the newton Europe review and latterly the Care Quality Commission system review can be used to influence the next stage of development of community based care to support system flow. We'll be using the developed narrative of the 'left Shift' to develop community capacity to meet future needs by increasing capacity and integration between current services to support flow.

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:	18,853

Integration success story highlight over the past quarter

We have used some iBCF/Spring Budget funding to increase the flow of patients in the health and care system by placing Case Officers in LTHT and having dedicated Social Work Assistants support timely exits from reablement where an ongoing service is required. This has:

- Increased the number of appropriate referrals to SKiLs from LTHT and reduced length of stay in hospital
- Reduced referrals from LTHT which don't become an active reablement intervention
- Reduced the number of people in transition from reablement and the length of time people are supported in transition by reablement

We are the process of recruiting a Trusted Assessor role (2 posts) who will support the relationship between the hospital and nursing and care homes, reducing the number of times people need to be assessed as suitable for specific care homes

Achievements in Q3 2018/19

- developed a Home First approach
- the Decision making Workstream (an output from the Newton Europe Review) has redefined the pathways from hospital, focussing on the Home First approach
- reduced delayed transfers of care from LTHT across all delay types

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.