Nottinghamshire County Council

Report to the Health and Wellbeing Board

7 November 2018

Agenda Item: 7

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH, NOTTINGHAMSHIRE COUNTY COUNCIL

BETTER CARE FUND PERFORMANCE

Purpose of the Report

1. This report sets out progress to date against the Nottinghamshire Better Care Fund (BCF) plan and requests that the Health and Wellbeing Board:

    - Approve the Q2 2018/19 national quarterly performance report.

Information and Advice

Performance Update and National Reporting

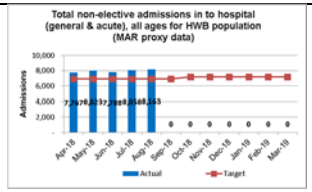
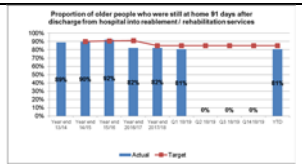
2. Performance against the BCF performance metrics and financial expenditure and savings continues to be monitored on a monthly basis through the BCF Finance, Planning and Performance sub-group and the BCF Steering Group.

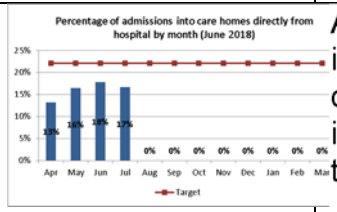
3. The performance update includes delivery against the six key performance indicators, the financial expenditure and savings, scheme delivery and risks to delivery for Q2 2018/19

4. This update also includes the Q2 2018/19 national quarterly performance template submitted to the NHS England Better Care Support Team for approval by the Board. This report has taken a new format and consolidates the BCF and Improved BCF quarterly returns.

5. Q2 2018/19 performance metrics are shown in Table 1 below. Three metrics are off track and three metrics are on plan.

Table 1: Performance against BCF performance metrics

REF	Indicator	2018/19 Targets	2018/19	RAG and trend	Trend	Summary of mitigating actions
BCF1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	20,767 Q2	8,163 August	R ⇧		Monitored by CCG Governing Bodies and A&E Delivery Boards.
BCF2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	555.4	523 YTD	G ⇔		Monitored by Nottinghamshire County Council ASCH&PP and the Older Adults Delivery Group. All placements are considered at panel and agreed where there is no viable alternative. Figures adjusted for admissions recorded in April but made during the previous financial year.
BCF3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85%	81% Q1	R ⇩		Monitored by Nottinghamshire County Council ASCH&PP. The percentage of people still at home after 91 days has reduced as reablement type services available upon discharge from hospital have expanded and are now offered to people with more critical needs.
BCF4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	554.3 Q2	188 August	R ⇧		**South -** Newton Europe system wide summits in June and July to identified five key areas to be addressed. Implementation plan in place. **Mid -** System-wide work-stream and action plan with a focus on out of area patients. **North –** Focus on facilitating discharges which are out of the CHC pathway. Successful bid to NHS Digital to roll out the sharing of records.

REF	Indicator	2018/19 Targets	2018/19	RAG and trend	Trend	Summary of mitigating actions
BCF5	Percentage of users satisfied that the adaptations met their identified needs	95%	100% Q1	G ⇔	⇔	
BCF6	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes	22.11%	15.1% Q1	G ⇔		As new reablement type services are implemented, system changes to ensure these can be appropriately recorded are prioritised as is communication with staff about the use of these services.

6. Reconciliation of Q1 2018/19 spend is complete and reconciliation of Q2 is underway. Expenditure is broadly on target with some in year slippage. Table 2 shows plan and forecast as at Month 5.

Table 2: 2018/19 spend at month 5

Contributing partner	**Nottinghamshire Clinical Commissioning Groups (CCGs)**	**Nottinghamshire County Council**	**Total**
£'000s			
Total spend to period 5	£14,298	£23,491	£37,789
Under/(over) spend to period 5	£0	-£440	-£440

7. The BCF Finance, Planning and Performance subgroup monitors all risks to BCF delivery on a quarterly basis and highlights those scored as a high risk to the Steering Group. The Steering Group has agreed the risks on the exception report as being those to escalate to the HWB (Table 3).

Table 3: Risk Register

Risk id	**Risk description**	**Residual score**	**Mitigating actions**
BCF005	There is a risk that acute activity reductions do not materialise at required rate due to delays in scheme implementation, unanticipated cost pressures and impact from patients registered to other CCG's not within or part of Nottinghamshire's BCF plans.	16	Monthly monitoring of non-elective activity by BCF Finance, Planning and Performance subgroup and Steering Group (currently only for activity in Nottinghamshire CCGs). Oversight by A&E Delivery Boards.
BCF14	There is a risk that the DTOC target will not be met in 2018/19	16	Further action is needed to review particular issues such as housing, weekend discharge and liaison with A&E Delivery Boards.

8. As agreed at the meeting on 7 October 2015, the Q2 2018/19 national report was submitted to NHS England on 19 October pending HWB approval (Appendix 1). Due to the timing of the report, the content for Nottinghamshire County was prepared and agreed by the BCF Finance, Planning and Performance sub-group and approved by the BCF Steering Group. If the HWB requests amendments to the report, the quarterly report will be resubmitted to the NHS England Better Care Support Team.

9. Further national reporting is due on a quarterly interval with dates to be confirmed.

Other options

10. None.

Reasons for Recommendations

11. To ensure the HWB has oversight of progress with the BCF plan and can discharge its national obligations for reporting.

Statutory and Policy Implications

12. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

13. The £80.5m for 2018/19 is forecasting an underspend at month 5 of £0.44m this relates to the Improved Better Care Fund however it is anticipated to be fully spent at the end of the year.

Human Resources Implications

14. There are no Human Resources implications contained within the content of this report.

Legal Implications

15. The Care Act facilitates the establishment of the BCF by providing a mechanism to make the sharing of NHS funding with local authorities mandatory. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected.

RECOMMENDATIONS

That the Board:

1. Approve the Q2 2018/19 national quarterly performance report.

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Constitutional Comments (LM 21/09/18)

16. The Health and Wellbeing Board is the appropriate body to consider the contents of the report

Financial Comments (OC 23/10/18)

17. The financial implications are contained within paragraphs 6 and 13 of the report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- "Better Care Fund: Guidance for the Operationalisation of the BCF in 2015-16". http://www.england.nhs.uk/wp-content/uploads/2015/03/bcf-operationalisation-guidance1516.pdf
- Better Care Fund – Final Plans 2 April 2014
- Better Care Fund – Revised Process 3 June 2014
- Better Care Fund Governance Structure and Pooled Budget 3 December 2014
- Better Care Fund Pooled Budget 4 March 2015
- Better Care Fund Performance and Update 3 June 2015
- BCF Performance and Finance exception report - Month 3 2015/16
- Better Care Fund Performance and Update 7 October 2015
- Letter to Health and Wellbeing Board Chairs 16 October 2015 from Department of Health and Department of Communities and Local Government "Better Care Fund 2016-17"
- Better Care Fund Performance and Update 2 December 2015
- 2016/17 Better Care Fund: Policy Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf
- Better Care Fund Performance and Update 2 March 2016
- Better Care Fund 2016/17 Plan 6 April 2016
- Better Care Fund Performance and Update 6 June 2016
- Better care fund Performance, 2016/17 plan and update 7 September 2016
- Better Care Fund Performance 7 December 2016
- Better Care Fund Performance March 2017

See also Chairs Report items:
TBC

Electoral Divisions and Members Affected

- All.

Appendix 1

Selected Health and Wellbeing Board: Nottinghamshire

2. National Conditions & s75 Pooled Budget

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		

3. Metrics

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Data not available to assess progress	North M1- M5 = 282 admissions over plan. Emergency Care over performance is both activity and casemix complexity driven. Admissions for pneumonia, COPD, heart failure, urology and sepsis are all higher than planned and higher than last year. This is of great concern as activity usually sees a reduction in activity at this time of year but in 2018/19 this hasn't happened. Additional work is been undertaken regarding Respiratory conditions as part of the Urgent Care Board as a task and finish group led by the Chief Nurse. Emergency readmissions within 30 days of discharge are also significantly higher than planned. There is a quality concern that patients are either discharged too early or are not appropriately managed post discharge. This is being followed up with the trust. Mid M5 YTD SUS: M&A = 9736 actuals v 9398 plan (+3.6%)	Emergency Activity continues to be discussed at A&E Delivery Boards. North: Emergency Activity continues to be discussed at both the joint A&E Delivery Board with Doncaster CCG and DBTHFT and the local Urgent Care Group. Mid: Non-elective activity is discussed at the A&E Delivery Board and supporting groups.	

			N&S = 5649 actuals v 5403 plan (+4.6%) The 2 Mid-Notts CCGs are not achieving the SUS plan submitted to the NHSE. The CCG has investigated this and a key driver in the 0 LOS admissions are 35 - 39 yr olds into T&O. It is understood this is linked to the hot weather and increased physical activity. Analysis has been undertaken to highlight GP practice levels above the mean. Any exceptions coming out of this analysis, together with the specialties showing high variances will be prioritised as target areas for admission avoidance QIPP schemes. It should be noted that some QIPP schemes required re-phasing to account for Full Year Effect and this was not played into the NHSE SUS plan. If this re-phasing is done, the outcome for M5 YTD is: M&A: -3.3% v plan N&S: -1.8% v plan This has been discussed with the NHSE. South YTD SUS v Operating plan at M5. NNE = 6202 actual v 5969 plan (+3.9%) NW = 3819 actual v 3554 plan		

			(+7.5%) Rush = 4569 actual v 4276 plan (+6.9%) Analysis highlights that the increase in admissions is driven by paediatrics, general surgery, and respiratory medicine. Paediatrics activity is 33% higher than the agreed contractual plan at August YTD. Meanwhile, respiratory activity is 23% higher and general surgery activity is 26% higher than the agreed contractual plan for the same period. The growth in paediatric admissions has been driven by an increase in diagnoses related to respiratory infections and viruses. There has also been a growth in same-day and short stay emergency admissions at NUH in 18/19 against the previous year. South Nottinghamshire CCGs has seen admissions from the 0-14 age group grow by 45% when compared against the same period in the previous year. There has also been a 13% growth in admissions for the 60-64 and 70-74 age groups in this same period. A contract query has been issued to NUH seeking further information regarding the growth in paediatrics and short stay admissions. This will be		

			discussed with the trust in the coming weeks with a response to the query being made available thereafter.		
Res Admiss-ions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Management of admissions to long term care is a constant challenge as the older population increases and have more complex care needs.	All admissions are approved at panel to ensure all other options have been explored prior to long term admission to a care home and admissions are currently on target.	
Reable-ment	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitatio n services	Not on track to meet target	This indicator includes some services that are offered to people with critical care needs and this makes achieving the 85% target challenging. New services have been implemented this year and will not appear in the results until later in the year.	The new 'Home First Response Service' service was implemented this year and this will significantly increase the number of people offered a reablement type service on discharge from hospital.	
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Data not available to assess progress	North Overall downward trend between April 2018 and July 2018 for the number of days delayed at DBTHFT for Nottinghamshire County Council area patients. 3 Main reasons for delays are Waiting for Further Non Acute NHS, Patient Family Choice and Completion of Assessment.	North Successful bid for funds from NHS Digital to allow the sharing of social care information with DBTHFT as per the work completed at Sherwood Forest. Mid - The Mid-Notts Urgent Care team is working closely with the Greater Notts Urgent Care Team and improvements will be	

			Mid SFHFT Total Trust (from local data) Apr18 = 885 (national = 5.1%) May18 = 727 (national = 3.9%) Jun18 = 904 There are specific challenges being addressed around the pathways for specific cohorts of patients, for example, non weight-bearing as there is no clear D2A route out of the hospital for these currently. South - NUH Total Trust Jun18 = 953 Jul18 = 836 Aug18 = 753 Downward trend for number of days delayed. Published data for August shows most common reasons for delays in the month are a lack of capacity in further non-acute NHS care and patients awaiting care package in their own home. Data analysis for Greater Nottingham highlighted that the most common reason for delay in transfers include a lack of capacity in further non-acute NHS care. Other less significant causes of delayed discharge were around completion of assessment and patient or family choice.	approached from an STP footprint perspective wherever possible. The further achievement of 3.8% against trajectory for July 2018 is being considered by the T&F Group in order to replicate 'What Good looks like' wherever possible. A&EDB agreed to incorporate all of the DTOC actions into a revised overarching plan which would be led by SFHFT and would also provide focus on 7+ and 21 day+ LOS. This will be reviewed at October's A&EDB meeting, along with an updated position on the relevant themes and trends. The combined working group has agreed which metrics should be used by the system to ensure that improvements are being delivered and this will feed into both A&EDB operational meetings, and Urgent Care Programme Board which has delegated authority from A&EDB to progress and monitor transformational urgent care schemes and pathways. The Home First Integrated Discharge Workstream task and finish groups are agreeing new pathways for non-weight bearing patients and those who require further CHC (continuing health care) assessments. These	

				pathways will go live from 01 November 2018 and significantly reduce delays. The first-cut Recovery Plan was completed in April 2018, together with a trajectory to reach 3.5% by September 2018. Actions include: o Ensure coding & reporting of DTOCs accurately reflects national guidance. The Health Community is inviting ECIST back to carry out a review of previous work. o Review of Discharge Policy (which also has a positive impact on the 95% A&E standard) and having clear documented escalation process in place across the system. o Increase proportion of discharges before 11:00am. o Implementation of Trusted Assessor (anticipated Go-Live in July). The DTOC action plan focusses on those patients who are in out-of-area acute hospitals, as well as those in Nottinghamshire hospitals to ensure equity of provision and patient experience. The Mid-Notts Urgent Care team is working closely with the Greater Notts Urgent Care Team	

				and improvements will be approached from an STP footprint perspective wherever possible and appropriate. The Achievement of 3.9% for May 2018 is being considered by the T&F Group in order to replicate 'What Good looks like' wherever possible. The CCG now receives information relating to Stranded Patients and this area will be incorporated into the DTOC Recovery Plan. South - The Newton Europe system wide summits in June and July identified five key areas to be addressed by the system following flow and patient delay diagnostic work. A implementation group is in place, which includes senior leaders to consider how the system can collaborate more effectively. There is also additional focus on reducing the number of patients staying in hospital longer than 21 days , which will contribute towards delivery of a reduction in delayed transfers of care.	

4. High Impact Change Model

		Maturity Assessment					Narrative			
		Q4 17/18	Q1 18/19	Q2 18/19 (Current)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Established	Established	Established	Established		North Interoperability Phase 1 target to share Social Care Information with ED staff has slipped from August 2018 to October 2018. Mainly due to technical staffing resources across DBTH. Mid We are confident that for elective patients and pathways the outcome is	North The Integrated Discharge Team team, including Discharge Co-ordinators, meets each morning (Monday to Friday) to discuss/review all patients referred for discharge planning. Other community and ward based staff such as therapists and nurses attend as required. Unnecessary barriers/delays to discharges are identified and dealt with as quickly as possible; and all staff work to facilitate a safe and timely discharge. A full time SW from	North Develop the Ward link staff role in promoting best practice in discharge planning. OOA patient pathways are being reviewed. Continued development of the Interoperability project to enable the sharing of social care information with health staff across DBTH especially linked to ED and the

								'established', though we do need to be sure that pre-admissions discharge planning takes place across General Practice in it's entirety. However, non-elective processes are not as advanced and embedded. We are confident that the internal work streams at SFHFT & the transformational plans for the remainder of 18/19 will deliver a Mature status. South Increased referrals for Pathway 1	the Rapid Response service covers the ED dept. to prevent unnecessary hospital admissions. Ward Discharge link staff have been introduced, focussing ward staffs on timely and effective discharge planning. Home first response service now in place and is effective in reducing length of stay in hospital. IDT workshops meet on 3 monthly basis with full engagement from all stakeholders linked to discharge planning. The voluntary sector now facilitate a quality discharge engagement to reduce avoidable re-admission, with special reference to social isolation. Mid Daily hub meetings with external	Wards. Further exploration of pre-op assessment process to include aspects of both health and social care needs to assist early discharge planning. Develop greater links with Care homes. Develop acute community interface with the 3 Primary care homes in Bassetlaw with the aim of 'pulling patients' through their discharge pathway. South Development of the Lancashire model to promote home first further within a safe

								has resulted in marked delay in home care packages in Nottingham City (to be reported via the Nottingham City BCF Quarterly Submission). Recent empty beds in community bed provision. Action plan in place to optimise capacity. Previous agreement to progress the Lancashire model, but now due to funding this is unable to be progressed at the moment.	partners. Home First Integrated Discharge work stream(previously the Intensive Recovery Roadmap workstream plan in place) will implement a lot for the required indicators for this, along with the SFHFT internal Improving Access to Urgent & Emergency Care Services work stream South - Emergency admissions have a predicated discharge date set within 48hrs of being admitted and are identified as being a “simple” or “supported discharge”. - 250 supported discharges weekly. Reduced DTOC to lowest number ever, as well as reduced Medically Stable For Discharge	and effective system. Paper to be presented at A&E Delivery Board as part of the wider funding discussion / requirements to support system flow. Increased capacity for an at home model required to increase the number of people going home and staying at home with support.

									>24hrs. - Average length of stay post Medically Stable For Discharge @ 2.2days. - Joint DTOC coding Standard Operating Procedure agreed across all organisations. - Multiagency training 'excellence in discharge planning' "trolley dash" education. - Education events planned with NHS Elect for IDF. Increased referral onto Pathway 1, reduced requirements for Pathway 2. - Red bag scheme in operation across the South. - Front Door Discharge team (12fte) work holistically (trained through Citycare competencies framework) and refer direct to START and Leivers accept “Transfer of Care” form for	

									admission to Leivers - County Social Care Home First Response Service 7 day service to bridge capacity OF Homecare and START	
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established	Established		North EMS Plus Escalation system to be developed further across DBTH to ensure all stakeholders input data linked to patient flow. Transport issues effecting discharge, they are logged and formally and escalated for solution. Mid Internal bed modelling work has taken place at SFHFT to provide a	North Discharge Coordinators feedback from all wards during IDT morning meetings. Demand management, escalations plans in place to increase external bed/care options to reduce DToC when the hospital is on high alert. Use of a monthly reporting identifies local delays and bottlenecks within the system. There is an escalation plan in place to solve the delays/bottlenecks. Monthly LOS meeting to review all patients who have a LOS in excess of 7 days which is attended by health	North Continue to monitor the new developments linked to the monthly LOS meetings to understand effectiveness. Also review the escalated Transport issues to determine action plan to reduce Transport issues. EMS Plus escalation system development to take place over the late Summer into Autumn. South Clarity

								seasonal bed model requirement. The system's Surge & Escalation plan details triggers for identifying increased demand and bottlenecks together with actions at each OPEL level. The STP is producing a demand and capacity dashboard, however this won't be ready for winter 18/19. S/C are producing a demand and capacity function which will allow the system to have sight of available resource. South	and social care and CCG partners. To reduce stranded and super stranded patients by 25%. Integrated IDT lead reps attend a daily operational flow meeting. There is a live web based portal system which details all the available care home beds in the Bassetlaw Health and Social Care system. Care homes update the system on a regular daily basis, with information available to the CCG, Social Care, acute and community staff. The system supports a more rapid discharge into the care home sector. DBTH are developing a bed management system with plans to go live in October. Mid Bed module of	regarding funding is required. D2A development has provided benefits for all system partners, therefore discussion about how all system partners support further developments.

								Care home live bed management system recommended to provide real time bed capacity within care homes. Funding stream to be discussed at A&E Delivery Board. The Home First Dashboard is to be reviewed with system partners to ensure it is accurate. Providers are contracted to complete the metrics to ensure the dashboard is meaningful, providing a true picture of system flow for the whole patient journey from	Nerve Centre being implemented & rolled out in early October 2018. A service is usually found for patients, an escalation process is in place & Social Care have limited flex capacity. South - established - Newton Europe review completed. Clinical Utilisation Review - recommendations completed. - Red 2 Green is in place in NUH and across community rehabilitation/reablement providers and monitored monthly. Identifying pathways; simple/supported (1, 2 or 3). - D2A metrics agreed and Dashboard framework in place with early data. - Nerve Centre at NUHT provides partners with the	

								admission to discharge.	status information on patients that are allocated to them to review - All supported discharges are triaged daily by health and social care within the Integrated Discharge Team - Nerve Centre provides bed capacity live data to monitor flow - County Social Care have an escalation plan and daily dashboard in place across social care teams within NUHT and wider services such as START/STIS/Leivers/ Homefirst/ Homecare - Allows managers to be proactive and flex resources where they are needed. It also provides a framework with clear processes when capacity across these services is full. This	

									allows social care to be proactive when reacting to the Opel status at NUHT	
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Established	Established	North mature - Robust IDT in place which is working effectively across health and social care, using a multi-agency team using a single assessment/referral document, used by health and social care staff, which is accepted by other community bed based providers and out of area providers.	North Develop greater links with Care homes. Develop acute community interface with the 3 Primary care homes in Bassetlaw with the aim of 'pulling patients' through their discharge pathway. Mid There are currently no system drivers to integrate budgets and workforce into a single provider. Therefore it is not	North Voluntary sector now engaged in a pilot to facilitate a quality discharge to reduce avoidable re-admission, with special reference to social isolation. Mid System providers work collaboratively with elements of integration, despite there being no single organisational structure South - Integrated Discharge Team across NUHT/Social Care (City/County)/Community health staff formed in October 2017 - IDT are working together to ensure appropriate plans are in place for all	South Education events have resulted in a reduction of DSTs being carried out in the acute environment. Issues identified within mental health as this is still classed as an 'acute environment'. Discussions with the central team have further clarified that patients in Highbury and equivalent facilities are not a sub acute environment, therefore contribute to the 15%. Work planned to

								expected that this indicator will meet 'mature' or 'exemplary' South Challenges to reduce DSTs in hospital to <15%.Progress being made to reduce DSTs in hospital. Work progressing with stroke to reduce the requests for DSTs and mental health patients.	'stranded' and super stranded' patients. - Thrice weekly health and social care meeting to look at top 20 on medically safe to ensure plans for discharge are in place with accountable lead. - Transfer Action Groups within NUH across the Divisions are in place. - Weekly complex patient review meeting with senior system partners to 'unlock' any issues with discharge plans. - Stranded and super stranded senior meeting taking place daily for 2 weeks - 98 patients reviewed, 28 discharged with a length of stay between 20-344 days. - Discussions with stroke services to promote D2A have been positive. Increased referrals	develop D2A principles across the Healthcare Trust inpatient beds. Increase in discharge to assess beds from stroke will develop a waiting list. CCG contracts team aware of this and will monitor community bed capacity closely.

									for stroke beds since seen.	
Chg 4	**Home first/discharge to assess**	Established	Mature	Established	Established	Established	North exemplary - No DSTs are completed in the hospital setting - There is robust local process in place.	Mid There is currently not a D2A / Home First pathway in place although a proportion of patients are assessed outside of an acute hospital setting. However the Home First Integrated Discharge work stream hasn't gone live as yet, & this will provide robust and consistent delivery for all patient groups. South Increased demand for home care package as	North The Fact Find document is being used to facilitate the discharge to assess model, to make direct referrals as part of timely hospital discharge where the community care assessment is then completed external to the hospital site, e.g. START services and Assessment beds at James Hince Court. There is an established discharge to assess framework in place to support the discharge of patients who may require assessment for CHC funding. Mid From 1st October there will be an integrated clinical navigation and urgent response service (C4C and I.H.S). Additional	South Discharge policy supported by all organisations. Letters will be generated as part of the discharge policy. Need to ensure the PALS teams are aware to ensure changes are communicated to patients as a result of enacting the discharge policy. Nottingham City home care capacity is limited due to the lack of external market workforce challenges. Approx. 90 people waiting for packages of care across

								part of home first.	actions will form part of the plan to address stranded and super stranded patients across the trust South - Weekly supported discharge target has been consistently achieved since October 2017. - One single "transfer of care " form agreed by all parties to discharge patients on pathway 2+3 - Home first ethos being embedded and leaflet to embrace home first developed - Reduction in medically safe for transfer (from 140-160 down to 107). - Reduction in daily DTOCs to 2%. - Excellence in Discharge training programme commenced in June. Trolley dashes across all wards on both sites are being	the acute beds, community and those waiting to be discharged from home reablement services to an external provider.

									targeted with drop in sessions. Next phase of this programme will be focussing on community. - Weekly complex review meetings take place. - Thrice weekly meeting to ensure top 20 on medically safe list have clear plans to enable discharge to happen with accountable leads. Escalation process in place. Above continues, with additional senior meetings to progress the stranded and super stranded. - Trusted Assessor in place for fast track patients at NUHT	
Chg 5	**Seven-day service**	Established	Plans in place	Established	Established	Established		North Acute trust currently reviewing the role of Ward Cordinators to cover a 7 day service. IDT staff currently	NorthThe Social care staff in the IDT currently provide a 6 day service which is being presently being evaluated, as health IDT staff plan to introduce over seven day working in the next few	NorthAcute trust to develop and support 7 day working within the IDT.SouthProviding a 7/7 service across the IDF

								work over 6 days and also cover bank holidays, plan to review IDT 7 day working requirements linked to capacity and demand. Care Home communicati on is ongoing with regards to accepting referrals/deci sion making for patients over 7 days. MidAs a system we are already displaying elements of 'mature' & exemplary. The challenge is that Home Care provider contracts are not set up to respond in the timeframe specified in the guidance	months. Positive results have already been reported regarding LOS and the efficiency of the discharge pathway. All current new posts have seven day working as part of their contract. Home First Response service accept referrals over 7 days. START service development is ongoing with regards to the provision of a 7 day service linked to accepting referrals.MidEnsure that discharge policy/processes & ambitions of relevant work streams align with the re-start time frames. South-Provider group working through this to put in place appropriate plans that should come into fruition prior to Winter. - County Social Care have a	requires additional funding.

								for re-started packages & the 7 day approach to this. However the new Home First Response Service funded by social care can respond within 24 hours providing capacity is available. SouthWorkforce change to support 7 day services. Whilst some services are in place to support 7-day working it is recognised there are gaps.	Rota system in place to cover weekend working-Work ongoing to develop 7/7 service for IDT in NUH, however funding required for additional staff to support this. Plan to extend the weekday working until 6pm.	
Chg 6	**Trusted assessors**	Established	Plans in place	Plans in place	Plans in place	Plans in place	North Mature - Since January 2015, the Bassetlaw Hospital IDT currently operate a	North Systemwide development approach required, for ward/IDT staff/Residen	North This is an ongoing development to move from some care providers to all care providers/Care homes being signed	North On going presence at the Bassetlaw Residential Care Home forum event.

							trusted assessor model of work. Robust IDT in place which is working effectively across health and social care, using a multi-agency team using a single assessment/referral document, used by health and social care staff, which is accepted by other community bed based providers and out of area providers.	tial care. Continue to monitor and improve. Continue to embed the trusted assessor model with local care homes. Mid The Trusted Assessor for Care Homes project has been delayed in Mid-Notts due to confusion over HR/Governance processes required. These have been resolved and mitigating steps are in place to prevent a re-occurrence of the same. However, there is no appetite	up the Trusted assessor model. Mid Recruitment to SFHFT post (Trusted Assessor for Care Homes). South - A Trusted Assessor model is progressing as a function within the Integrated Discharge Team at NUHT, with health and social care colleagues developing a set of competencies and a bespoke training package to allow this multidisciplinary team to complete a "Transfer of Care "document to determine the pathway of a patient on each other's behalf. The "Transfer of Care "document has all the relevant information to allow a provider to accept	South Trusted assessor actions for care homes are being led by County Council on behalf of the system - CCGs to support development.

								locally for the utilisation of a single form, but partners continue to review opportunities to streamline working processes moving forwards. We are unable to commit to 'Mature' or 'Exemplary' if the indicators in the guidance are not to be deviated from. South Trusted assessor actions for care homes are being led by County Council on behalf of the system	the patient into their care in the community. - Nottinghamshire County Council is also leading on a Trusted Assessor model for Care Homes, where the Nottinghamshire Care Association are recruiting Trusted Assessor to independently assess patients on behalf of care home managers for a six month pilot. Interviews taking place this week.	
Chg 7	**Focus on choice**	Established	Established	Established	Established	Established		North The IDT focus on choice is an integral	North Within DBTH a Discharge Passport is given to all	Training plan in place to implement the

								part of the discharge discussion at all stages, however there is no formal Choice Protocol in place. Mid For this indicator the voluntary sector contribution is mature, however the remainder is plans in place. We are almost established and the work taking place in the work streams and improvement plans will deliver mature for the end of the financial year. A pt. leaflet is currently in development	patients who are admitted to hospital, providing relevant information regarding the hospital admission and discharge process pathways. The content of the passport is currently being reviewed to reflect new developments linked to discharge pathways. Mid SFHFT are reviewing & updating the discharge policy & patient choice will continue to be captured. HIC workshop on patient choice has been attended by system partners. Proposed discharge policy has a strong patient choice focus South '- Discharge policy ratified by A&E delivery Board on 4 September 2018	discharge policy.

								for the STP footprint and the discharge policy is being revised & training will subsequently be given. South Support for staff when implementing the discharge policy. Training programme to be agreed with providers to enable staff to enact the Discharge Policy and consistently deliver the same messages about leaving hospital and support required to enact it.	and agreed by all providers. - Connect worker insitu at QMC/City to accept referrals from social care - Patient choice event has provided tools to increase communication with patients regarding patient choice	

Chg 8	**Enhancing health in care homes**	Established	Established	Established	Established	Established	North mature - Well established work into care homes via the care home forum and other work projects	Mid The system needs to understand how a zero tolerance approach to admissions from care homes during weekends could be facilitated and monitored, including how care home contracts might support this. CQC status is variable and work needs to take place to standardise. South Enhanced care service to care homes in County, review of service for Nottingham	North Bassetlaw CCG holds care home forums twice yearly to influence and inform care home development, linked to hospital admission avoidance and facilitating hospital discharge; these forums also offer joint training sessions. The local authority quality market management team continually work with local Residential/Nursing care homes to raise standards and the quality of care within those homes, through announced and un-announced visits. Mid Care Homes scheme is in place and working well, care homes have access to *6. Care Homes forum provides education, training	North Development of the links between DBTH and the Primary Care Homes strategy of specific GPs linked to care homes. South Care homes will receive continued support from their respective CCG leads.

								City who decommissioned their enhanced service from 1 April 2018. Need to monitor if any impact, i.e. increased ED activity.	and support for care homes. Red bags to be rolled out imminently. EHCH Lead in CCG. Community services provides a care home team currently working with 11 care homes to provide education and support to ensure the safe care of the residents and prevent unnecessary admissions to hospital, this has had a positive impact and as reduction in admissions. South - STP Urgent & Emergency Care Group agreed to prioritise 'frequent activity' in all areas, which includes care homes. - The BCF fund Optimum to work with care homes to enhance care and avoid admissions	

									- Established champions to train staff in identifying signs and actions to take to reduce hospital admissions. - Spot purchase care home bed framework and escalation being developed, to ensure contingency for times of escalation and greater community bed demands.	

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.									
	Q4 17/18	**Q1 18/19**	**Q2 18/19 (Planned)**	**Q3 18/19 (Planned)**	**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	Established		Mid PMO team from SFHFT weren't involved in the project from the start of the project & this was a key element, lessons learned have been reflected on to respond to this. The Trusted Assessor post is a key interdependency and this has been delayed. South Ongoing work to ensure repatriation of red bags to care homes following the death of a resident in hospital.	North The Red Bag scheme has been fully implemented in Bassetlaw care homes. The scheme provides continuity of care and aims to reduce length of stay by ensuring a smooth and effective transfer from the hospital back to the care homes. Mid The distribution of red bags commenced at the Mid-Notts care homes forum on 27 September 2018. Go Live is planned for October when SFHFT governance is finalised. The working group is planning how to measure the improvements and outputs of this scheme. South Red bag scheme rolled out across	South Care homes will receive continued support from their respective CCG leads. Further funding for additional care homes being built. Responsibility of repatriation of red bags to be discussed.

									Greater Nottingham care homes on 02.10.2017. All frail older patient care homes aware and engaging with project. Many using the red bag as well as all the accompanying paperwork such as CARES escalation record.	

5. Narrative

Progress against local plan for integration of health and social care
In Nottinghamshire we have maintained our ambition for a strong BCF plan across our Health and Wellbeing Board footprint. Performance against all BCF metrics continues to be monitored monthly to ensure timely actions where plans are off-track. There continues to be a high level of commitment from partners to address performance issues e.g. daily discussions within hospitals to facilitate timely discharges, the development of transfer to assess models to reduce long term admissions to care homes, District Authority alignment with Integrated Discharge Teams to ensure housing needs of patients are addressed prior to discharge and avoid unnecessary delays. The 6 CCGs continue to work with local authority, District and Borough Councils, acute, mental health and community trusts and the community and voluntary sector in their 3 units of planning to ensure service transformation with a focus on reducing non-elective admissions and attendance, and care home admissions. Plans to accelerate improvement in trajectories are forecast to deliver further improvements as projects and programmes mature and transfer of investment and resources to primary and community setting manages demand more appropriately.

Integration success story highlight over the past quarter
Case examples showing how co-location has made a difference to front-line staff working in Mansfield (Mid Nottinghamshire) a) A social worker was organising some respite care for a service user who would need a pressure mattress in the residential home. Prior to co-location, the staff member would have called Call for Care SPAR to order the mattress and then wait for a call back from the relevant nurse to provide the details. Due to co-location, the worker went downstairs to speak to the relevant nurse in person, who ordered the mattress there and then. The social worker was worried that the mattress ordered was not the same as the one that the person had at home but the nurse was able to reassure her that this was acceptable for the short period of respite. b) Health staff spoke to the ASCH Team Manager about some residents of Woodley House, where safeguarding concerns were being raised. They agreed that the team manager would attend the next handover meeting of the Community Nurses, to discuss the cases in more detail. This would never have happened prior to co-location. c) A service user in a social care assessment flat was ready to go back home. The social worker involved spoke to the health OT and physio, who agreed to accept the person as a referral and support the move back home. d) An OT from the LICT came to speak to social care staff about benefits issues for a patient. The OT was signposted to the CSC but staff also suggested that the person could have a full benefits assessment at the hospice day service, which he/she was already attending. e) A joint visit carried out by a health OT and social worker. They discussed the case together and the ASCH Team Manager agreed it was appropriate to accept for social care and the visit was sorted out very quickly due to all being in the same office for the conversation. f) A safeguarding issue for a care home resident with diabetes – social care worker came back from a visit with concerns and was able to talk to the Diabetes Nurse Specialist and then involve her at the Safeguarding meeting. g) A district nurse came to talk to the social care manager about a recent visit where the nurse had changed a leg dressing for a man who carried on watching porn on a tablet. His record on Mosaic revealed a safeguarding alert related to this behaviour. This triggered the client being sent a warning letter from the NHS and the case was transferred to a male District Nurse. This was also about sharing risk information. h) Community Nurse discussed concerns with ASCH Team Manager and was signposted as the person was a younger adult, however we were able to check Mosaic to see if previous concerns had been raised. i) Information of risk regarding a dangerous dog shared with Health Co-ordinator so that she could put an alert on system one to reduce risks to visiting health professionals. j) Health Team Leader discussed a MASH referral with ASCH Team Manager as she felt the risks were high and the referral had not been progressed. Looking at Mosaic, the ASCH TM was able to provide feedback and an update on what was happening. In addition - ongoing queries from health staff to find out care package details for their patients and seek advice on appropriate referrals to social care and MASH. The social care managers feel that these are all very appropriate discussions.

6. Additional improved Better Care Fund

	2017/18	2018/19	If rates not yet known, please provide the estimated uplift as a percentage change between 2017/18 and 2018/19
1. Please provide the average amount that you paid to external providers for home care in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per contact hour, following the exclusions as in the instructions above)	£ 15.52	£ 16.26	
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions as in the instructions above)	£ 549	£ 555	
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+ in 2017/18, and on the same basis, the average amount that you expect to pay in 2018/19. (£ per client per week, following the exclusions in the instructions above)	£ 576	£ 611	
4. If you would like to provide any additional commentary on the fee information provided please do so. Please do not use more than 250 characters.			