Nottinghamshire County Council

Report to the Health & Wellbeing Board

4 March 2020

Agenda Item: 8

REPORT OF THE CORPORATE DIRECTOR FOR ADULT SOCIAL CARE & HEALTH

BETTER CARE FUND PERFORMANCE AND PROGRAMME UPDATE (QUARTER 3, 2019/20)

Purpose of the Report

1. This report sets out progress to the end of Quarter 3 against the Nottinghamshire Better Care Fund (BCF) budgets and performance targets.

2. It requests that the Health & Wellbeing Board approve the Quarter 3 national Better Care Fund return (shown in Appendix 1) which was submitted to NHS England on 24 January 2020.

Information and Advice: Performance Update and National Reporting

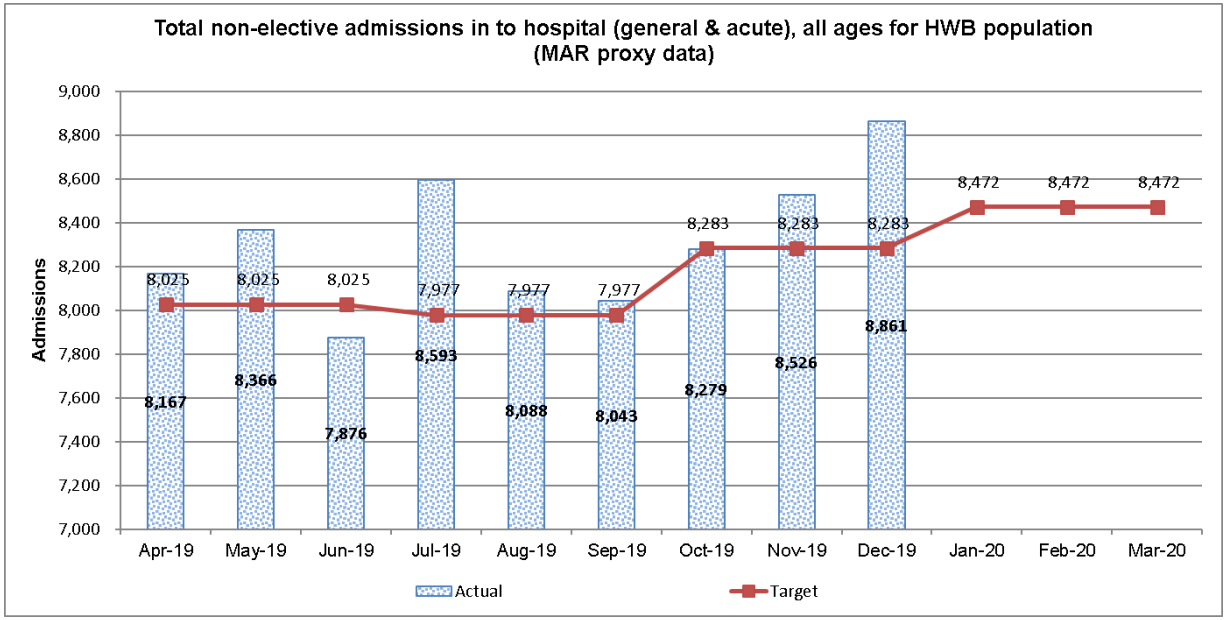
3. Performance against the BCF performance metrics and financial expenditure and savings continues to be monitored bi-monthly through the BCF Finance, Planning and Performance Sub-Group and bi-monthly through the BCF Steering Group.

4. This performance update includes delivery against the six key performance indicators, the financial expenditure and savings, scheme delivery, and risks to delivery for Quarter 3 2019/20.

5. The frequency of national reporting on BCF performance to NHS England has changed in 2019/20 and Quarter 3 is the first instance of this in this financial year. All local BCF partners developed and agreed the Quarter 3 BCF National Return at Appendix 1 that was submitted to NHS England by the deadline of 24 January 2020. Due to timings and in line with established practice, the National Return is now submitted to the Health & Wellbeing Board for retrospective approval.

6. Quarter 3 2019/20 performance metrics are shown in Table 1 below.

Table 1: Performance against BCF performance metrics

Ref'	Indicator	2019/20 Target	2019/20 Actual	RAG and trend	Key issues and mitigating actions
BCF 1	Total non-elective admissions (NEA) in to hospital (general & acute), all-age	72,855 Year to M9	74,798 Year to M9	Amber ⇔	

Nottingham and Nottinghamshire Clinical Commissioning Groups:

There are several non-elective Quality, Innovation, Productivity & Prevention (QIPP) schemes in place for Clinical Commissioning Groups in Mansfield and Ashfield, and Newark & Sherwood, which focus on admission avoidance for the frail elderly, those with Ambulatory Care Sensitive (ACS) conditions and patients on an end of life pathway. The End of Life and High Intensity Service Users schemes are currently delivering above plan. However, the Frailty Scheme and the workstream to address ACS conditions (Integrated Rapid Response Service) are behind schedule in terms of the impact they were intended to deliver.

A deep dive into non-elective admissions has occurred and findings have been fed into the local demand avoidance (south Nottinghamshire) and drivers of demand (mid Nottinghamshire) groups. These groups are responsible for mobilizing and monitoring

schemes aimed at reducing non-elective demand at both acute trusts. As demand has continued to rise over winter the analysis is being refreshed to investigate whether there are new themes that can form the basis of 2020/21 plans.

East Midlands Ambulance Service (EMAS) has mobilized a non-injury falls pathway which will be aligned with the Call for Care falls pathway to reduce the number of patients who fall being conveyed to hospital unnecessarily. A non-conveyance program is in place and EMAS have appointed a non-conveyance lead to facilitate this work. Call for Care is now live across all of Nottinghamshire, ensuring a two-hour response for those at risk of hospital admission.

The new 111 Clinical Assessment Service (CAS) went live in October 2019. This will result in more calls to 111 receiving clinical triage to reduce the risk of attendance at A&E and/or admission to hospital.

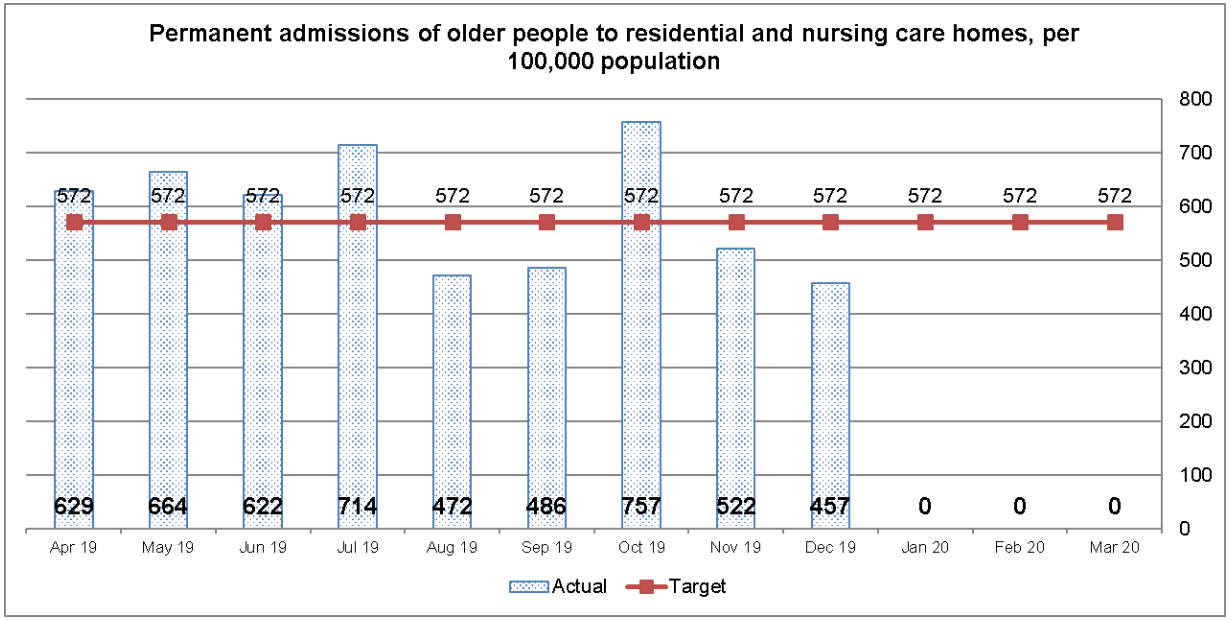
Mid Nottinghamshire:

'Drivers of Demand' is commissioned by the Nottingham & Nottinghamshire Integrated Care System in response to the growing non-elective demand being seen across the county.

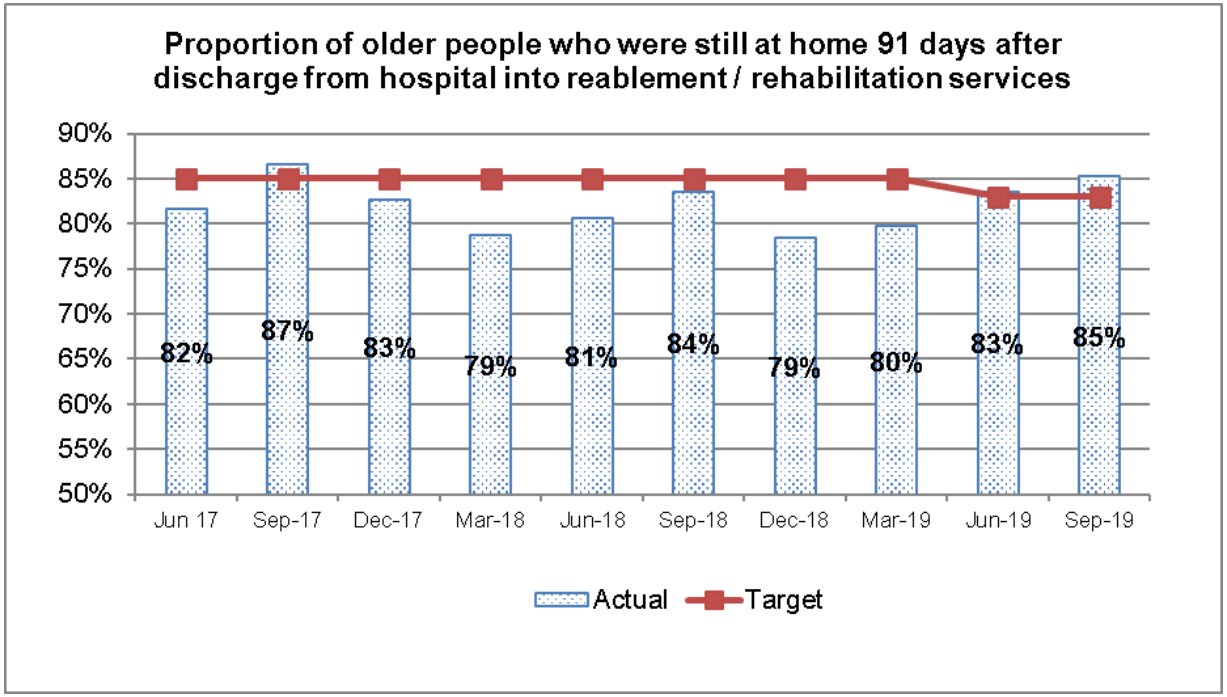
The analysis indicated there is no single reason for the increasing demand, and that several factors may be contributing. Nine key areas were identified, including:

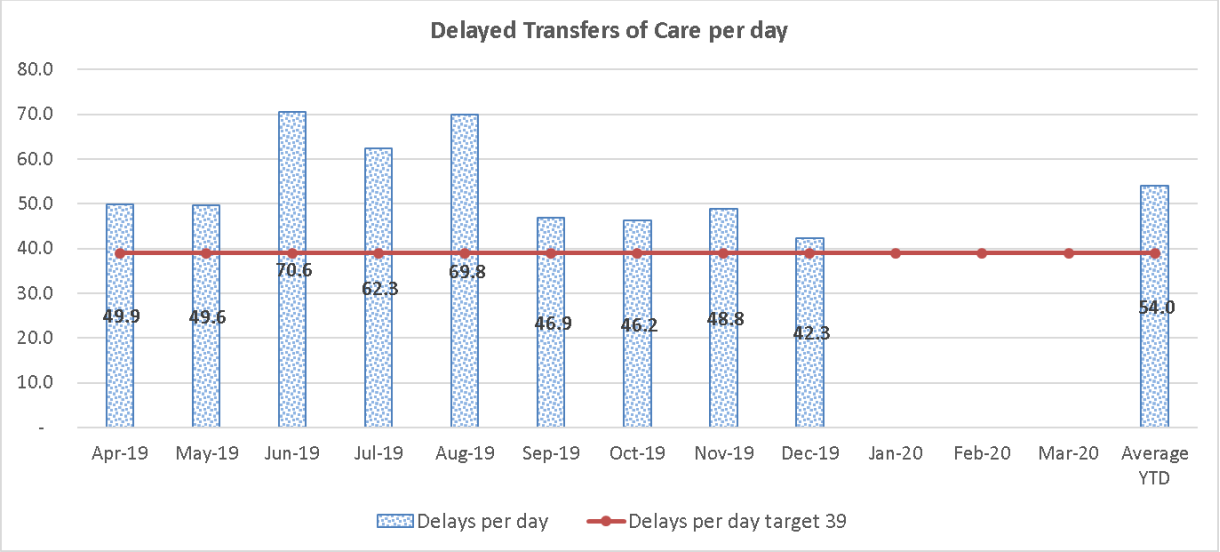
1. Community Services Review
2. GP Demand and Impact of Drivers of Demand
3. IRRS Model Development
4. Review of DOS and link to 111
5. Streaming to PC24 and NEMS Capacity Confirmation
6. GP Cover and the amalgamation of the GP Duty Cover into Newark Hospital, and potential to explore the opportunity to replicate in Sherwood Forest Hospital
7. Intervention for Drugs and Alcohol related conditions (included in action 3 IRRS model)
8. East Midlands Ambulance Service Conveyance Rates
9. Care Homes.

Action plans have been implemented for some of these areas whilst others still need further resources and data before starting. One of the action plans that has been implemented is Care Homes; this has already shown a positive impact on reducing the number of NEAs.

					North Nottinghamshire: Bassetlaw Hospital continues to see an increase in A&E attendances and subsequent admissions to hospital this year. The Clinical Commissioning Group invested considerably for this year's emergency / unplanned activity both in the hospital and to introduce the Call for Care model in Bassetlaw, and to utilize health and social care data / predictive analytics tools already used in Mid and South Nottinghamshire. The Clinical Commissioning Group will continue to work with all partners in efforts to minimize the increase in activity. At the end of Quarter 2, emergency admissions were slightly over plan by 81 admissions (1.2%).
BCF 2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	572	See graph	**Amber** ⇔	 Monitored by Nottinghamshire County Council's Adult Social Care & Health Department. Please note that admissions reporting has a time input-lag factor for each calendar month (e.g. admissions at the very end of the calendar month will not be reflected until the following month) which is why the previous month's admissions rates usually increase upon revision for the next monitoring report. The data is provisional (with ratified national data published annually).

					Headlines: • 34% of admissions are to nursing care and 66% are to residential care. • Admissions for the current year are now over target (741 against a year-to-date target of 720). • Last year there was a total of 979 admissions. This year's admissions could potentially exceed 1,000. • Average number of admissions per month is currently 85 (against a monthly target of 80). • Numbers of admissions have remained consistent over the last few years. • Admissions are highest in Bassetlaw, lowest in Ashfield and Mansfield. This indicator is likely to be higher than target by year end. Currently the County Council benchmarks within the top end of the average banding across other councils nationally and regionally. As data comes in for the winter period however the situation potentially becomes more volatile as an increased number of people present with more critical needs, meaning results for these indicators may change. It is becoming increasingly difficult to maintain this target on track. As an increasing number of older people with a range of needs require support, a more strategic approach with partners to developing options for older people is required to ensure that people are not being placed in residential care that could have been avoided / delayed. A BCF workstream has been established with partners to consider options for a more integrated Housing Options Pathway and development of a continuum of housing options suitable for people as they age, from mainstream housing through to supported. Having a greater range of suitable housing alternatives available will enable social care to support more people at home for longer and thereby reduce / delay the need for residential care. The number of new admissions is monitored against a target of 80 per month. Admissions into long-term care are avoided where possible through scrutiny of all requests for placements by Team Managers / Group Managers to ensure that all alternative options to promote a person's independence have been explored.
BCF 3	Proportion of older people (65+) who were still at home 91 days after discharge from hospital into a	83%	85%	**Green** ⇧	Reablement services support people to regain their independent living skills and confidence following a period of ill-health, which often has required a stay in hospital. This is good for people's health and wellbeing, and in turn reduces the need for health and social care and support services. This indicator (except for 10 jointly managed social care and health beds in Bassetlaw) captures the outcomes for people receiving

	reablement / rehabilitation service				social care (directly delivered and externally contracted) home and accommodation based reablement services. Reasons for people not remaining at home after reablement, include being admitted to long-term residential or nursing care, being re-admitted to hospital or having deceased.  This indicator is on a positive upward trend due to successful delivery of key transformation projects to increase capacity in the County Council's services and sustain or improve outcomes that help people remain living at home. This quarter, the target has been exceeded. Included in this indicator are short-term reablement services, including: • START: Nottinghamshire County Council's Short Term Assessment & Reablement Service provided in a person's own home (e.g. to help them regain their independence following a stay in hospital) • Home First Response Service: a short-term, rapid-response service provided by the independent sector which can support people to remain at home in a crisis or return home from hospital as quickly as possible • Social care assessment and reablement units: an assessment and reablement

					service delivered in an accommodation-based setting following a stay in hospital. In this period, out of the 682 older adults who received a reablement service on discharge from hospital, 587 people were still at home 91 days after. Figures show Nottinghamshire benchmarks as having a higher than average number of people not completing their reablement due to being re-admitted to hospital very soon after the reablement team starts to work with them. Nottinghamshire County Council is working with health colleagues in hospitals to understand the reasons for this.
BCF 4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	39/day	54/day	**Amber** ⇧	 A&E Delivery Boards in Bassetlaw, Mid Nottinghamshire and Greater Nottingham are responsible for the local urgent and emergency care systems and activity. There is a disconnect between the Delayed Transfers of Care (DToC) indicators required within the NHS Constitutional Standards and managed by A&E Delivery Boards, and the DToC indicator outlined in the Better Care Fund. Clinical Commissioning Groups are reporting that performance is in line with the NHS target of delays below 3.5% of monthly occupied bed days. **Nottingham and Nottinghamshire Clinical Commissioning Groups:** Nottingham DToC rates are beginning to decrease from a high of 3.81% in June 2019 to 2.84% in September 2019.

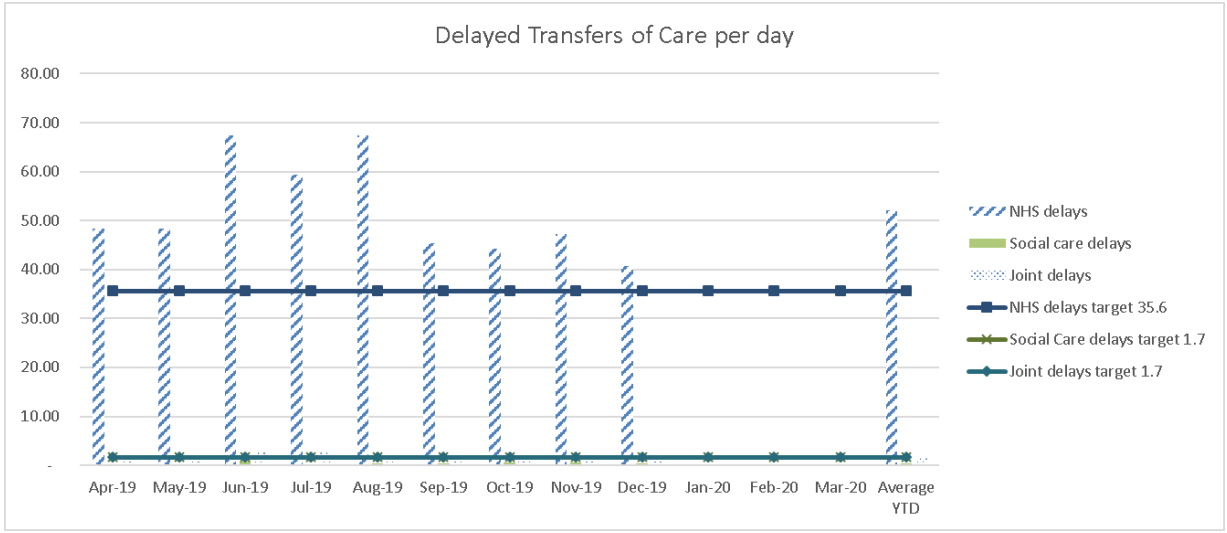
This equates to 1,217 delayed bed days in September 2019 which is a decrease of 311 from August 2019. Bed day delays are attributed to the NHS (86.1%), Social care (9%) and joint (4.9%).

Issues contributing to the change in DToC rates and delayed bed days include:

- Inclusion of patients that are in community beds.
- Increase in complexity and dependency of patient (e.g. bariatric patients who require two or more carers or specialist equipment).
- Increase in housing and homelessness discharge issues, particularly relating to complex needs such as wheelchair access or patients' eligibility to public resource.

Actions being taken to improve performance include:

- Coding queries being reviewed by the CCG data analyst teams.
- CCG working with partners to carry out a review of discharge pathways for homeless patients.
- Incorporating new specialist homeless discharge navigators.
- Developing an integrated homeless health pathway to enable proactive care planning and scoping potential for interim beds.



					Mid Nottinghamshire: As part of the Mid Nottinghamshire response to the level of DToCs it has been agreed that the HFID will now focus on discharge to assess and non-weight bearing pathways. In addition, the following actions have been undertaken: • A weekend discharge pilot has improved the level of discharges over the weekend. • A joint pilot combining the community and acute therapy teams is currently taking place to share learning and improve processes around discharge. • The over 21 and 7-day patient process is fully embedded and has resulted in a reduction in length of stay for these cohorts of patients. • A visit to Luton & Dunstable (a top DToC performer) to look at opportunities that system partners could adopt to improve timely discharges. **North Nottinghamshire:** Bassetlaw Hospital's share of the total DToC position has decreased significantly over the past year and comparing to the Nottinghamshire County Council total rate per 100,000 population at about 1/3 of the total. The Integrated Discharge Team will continue to work with Nottinghamshire County Council colleagues and community care providers to ensure delays are kept to a minimum. The Bassetlaw Call for Care service went live on 29 July 2019. Call for Care is the urgent care navigation service commissioned to deliver a two-hour response for people in Bassetlaw to prevent an avoidable hospital admission or support timely discharge from the Emergency Department. In Quarter 2, Nottinghamshire County Council delays at Doncaster & Bassetlaw Teaching Hospitals, averaged at 2.2 days delayed per day. **Countywide:** Excellent social care performance continues to be sustained across the county on this indicator; benchmarking shows that for social care delays Nottinghamshire County Council is consistently one of the top performing authorities in the country. The latest available data shows delays due to social care at a rate of 0.1 compared to a target of 0.7. Joint delays (where responsibility is shared with Health) are also performing better than target at a rate of 0.2 against a target of 0.55. BCF funded hospital-based social workers, integrated care teams, integrated patient / service user information systems, Home First and reablement services (START) have

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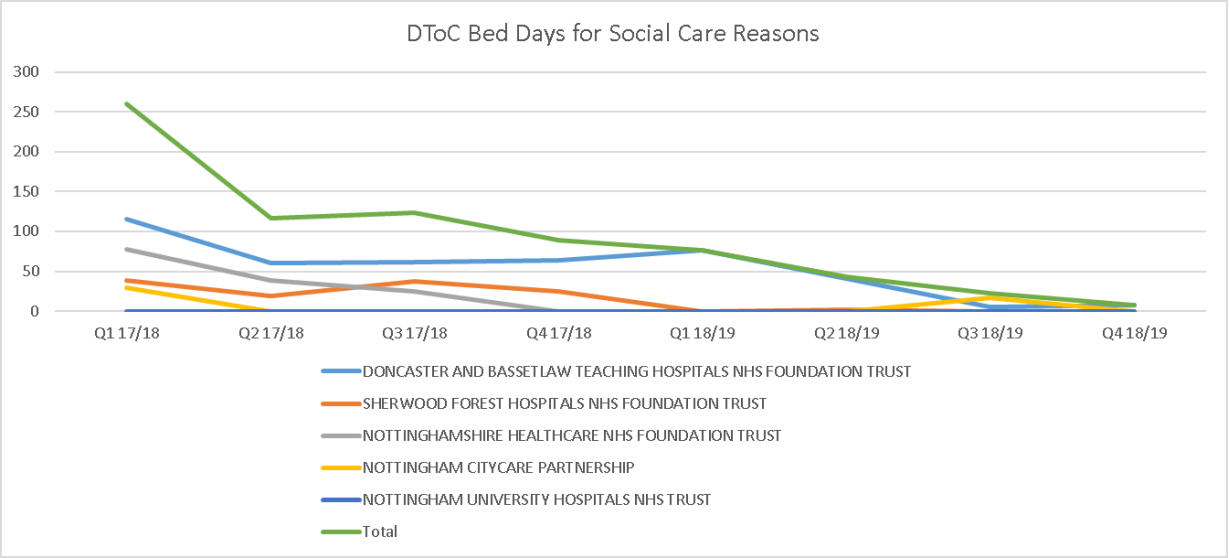
<tr><td></td><td></td><td></td><td></td><td></td><td>all made a positive contribution to reducing or eliminating delays for social care reasons.
 
</td></tr>
<tr><td>BCF 5</td><td>Percentage of users satisfied that the adaptations met their identified needs</td><td>95%</td><td>99%</td><td>Green ⇧</td><td>
<table>
<tr><th></th><th colspan="3">Q1</th><th colspan="3">Q2</th><th colspan="3">Q3</th></tr>
<tr><th></th><th>DFGs completed</th><th>No of customers satisfied</th><th>% satisfied</th><th>DFGs completed</th><th>No of customers satisfied</th><th>% satisfied</th><th>DFGs completed</th><th>No of customers satisfied</th><th>% satisfied</th></tr>
<tr><td>Bassetlaw</td><td>21</td><td>21</td><td>100%</td><td>20</td><td>20</td><td>100%</td><td>43</td><td>43</td><td>100%</td></tr>
<tr><td>Total North Notts</td><td>21</td><td>21</td><td>100%</td><td>20</td><td>20</td><td>100%</td><td>43</td><td>43</td><td>100%</td></tr>
<tr><td>Ashfield</td><td>14</td><td>14</td><td>100%</td><td>15</td><td>15</td><td>100%</td><td>30</td><td>30</td><td>100%</td></tr>
<tr><td>Mansfield</td><td>21</td><td>21</td><td>100%</td><td>14</td><td>14</td><td>100%</td><td>14</td><td>14</td><td>100%</td></tr>
<tr><td>Newark & Sherwood</td><td>19</td><td>19</td><td>100%</td><td>14</td><td>14</td><td>100%</td><td>23</td><td>23</td><td>100%</td></tr>
<tr><td>Total Mid Notts</td><td>54</td><td>54</td><td>100%</td><td>43</td><td>43</td><td>100%</td><td>67</td><td>67</td><td>100%</td></tr>
<tr><td>Broxtowe</td><td>14</td><td>14</td><td>100%</td><td>5</td><td>4</td><td>80%</td><td>9</td><td>9</td><td>100%</td></tr>
<tr><td>Gedling</td><td>17</td><td>16</td><td>94%</td><td>25</td><td>25</td><td>100%</td><td>26</td><td>25</td><td>96%</td></tr>
<tr><td>Rushcliffe</td><td>9</td><td>9</td><td>100%</td><td>11</td><td>11</td><td>100%</td><td>17</td><td>17</td><td>100%</td></tr>
<tr><td>Total South Notts</td><td>40</td><td>39</td><td>98%</td><td>41</td><td>40</td><td>98%</td><td>52</td><td>51</td><td>98%</td></tr>
<tr><td>Overall customer satisfaction</td><td colspan="3">99.1%</td><td colspan="3">99.0%</td><td colspan="3">99.4%</td></tr>
</table>
</td></tr>
<tr><td>BCF 6</td><td>Permanent admissions of older people (aged 65 and over) to residential and nursing care</td><td>11%</td><td>16%</td><td>Amber ⇧</td><td>Please note, this target has been halved from 22% (green indicator) in 2018/19.

This local admissions indicator measures the number of admissions to long-term residential or nursing care direct from a hospital setting where the service user did not have access to any reablement type activity beforehand. Positive progress has been</td></tr>
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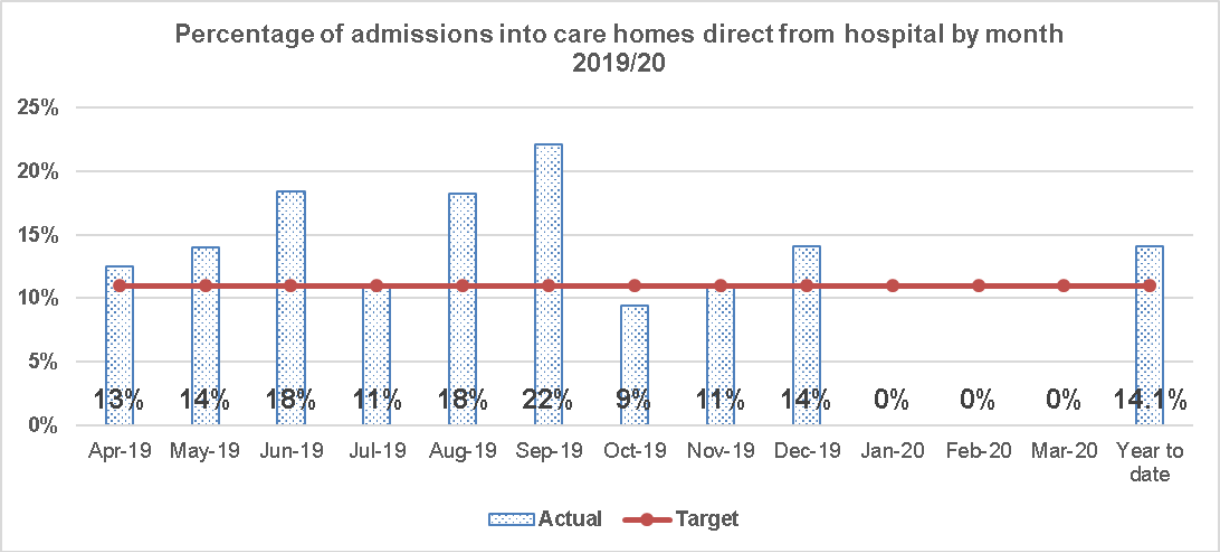
	homes directly from a hospital setting per 100 admissions				made on this indicator last year with a year-end out turn of 14%. This is in line with system partner plans for increasing numbers of people to be discharged from hospital either directly home, or into a short-term reablement service prior to having an assessment. This avoids the need for people to make decisions about their future longer-term care and support needs whilst still in hospital (known as Discharge to Assess).  The target for this indicator has been set at a challenging 11% for 2019/20 to build on last year's positive performance. At the end of quarter 2 however 18% of admissions came direct from hospital. The year to October shows a positive reduction down to 16%. Work is underway to check the data and reasons for performance deteriorating so that an improvement action plan can be put in place.

7. Expenditure is on plan in Quarter 3 2019/20 as shown in tables 2 and 3 below.

Table 2: Quarter 3 2019/20

Contributing partner	**Nottinghamshire Clinical Commissioning Groups (CCGs)**	**Nottinghamshire County Council**	**Total**
£'000s			
Payments made into pooled budget	£41,444,753	£29,459,118	£70,903,870
Payments received from pooled budget	£25,355,740	£45,548,130	£70,903,870
Total spend to period 9	£25,355,740	£45,548,130	£70,903,870
Under/(over) spend to period 9	£0	£0	£0

Table 3: Quarter 3 2019/20 Nottinghamshire County Council

£'000s	**Planned Spend**	**Spend**	**Variance**
Protecting Social Care	£13,461,400.26	£13,461,400.26	£0.00
Carers	£1,001,111.86	£1,001,111.86	£0.00
Care Act Implementation	£1,626,500.58	£1,626,500.58	£0.00
Winter Pressure	£2,645,302.50	£2,645,302.50	£0.00
Improved Better Care Fund	£19,863,119.25	£19,863,119.25	£0.00
Disabled Facilities Grant (District / Borough Councils)	£6,950,696.00	£6,950,696.00	£0.00

8. The BCF Finance, Planning and Performance sub-group 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 Health & Wellbeing Board (table 4).

Table 4: Risk Register

Risk id	**Risk description**	**Residual score**	**Mitigating actions**
BCF005	There is a risk that acute activity reductions do not materialize at required rate due to schemes not delivering the intended outcomes, and / or unanticipated cost pressures and / or impact from patients registered to other CCGs not within or part of Nottinghamshire's BCF plans.	12	• Regular monitoring through BCF Steering Group and BCF Finance, Planning and Performance subgroup as well as local governance forums. • Mid Notts Alliance Oversight Board, A&E Board and Better Together Proactive and Urgent workstream leads providing substantial focus.

BCF009	There is a risk that the available workforce does not meet the volume or skills required for the scale of transformation required or the future system needs.	9	• Monthly monitoring through A&E Delivery Boards, System Resilience Group and Transformation Boards. • Workforce development plan in place, including a succession plan. • Discussion with regional workforce teams to facilitate long term recruitment and development planning. Review recruitment and retention plans (annual). • Reduce scale of services and/or phase delivery to accommodate extend recruitment timescales. • Use of locum staff to bridge gaps.
BCF012	There is a risk that the target for the BCF2 metric (care home admissions) will not be met at year end and that this will not be known until late in-year due to how data is reported (retrospectively amended).	9	Admissions are monitored monthly and are approved by Group Managers at regular panel meetings on a district basis. There is a recognized lag in the recording of admissions onto the system, and staff are regularly encouraged to ensure that updates happen as soon as possible. This issue and the lack of a pattern in terms of the numbers of monthly admissions can make it difficult to predict if the number of admissions will be on target by year end.
BCF014	There is a risk that the DToC target will not be met.	16	CCGs and A&E Delivery Boards are pursuing several schemes to address the ongoing challenge to reduce NHS Delayed Transfers of Care as outlined in the performance indicator section of this report.
BCF016	There is a risk that the target for BCF3 (reablement 91 days) of 83% will not be met.	12	This indicator is monitored at the Performance Board and the Older Adults Interventions Board. There is an action plan in place to address issues with specific districts and service providers.

Other options

9. None.

Reasons for Recommendations

10. To ensure the Health & Wellbeing Board has oversight of progress with the Better Care Fund plan and can discharge its national obligations for reporting.

Statutory and Policy Implications

11. 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

12. At month 9, the 2019/20 annual Better Care Fund Pooled Budget of £92.2m is forecast to break-even.

Human Resources Implications

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

Legal Implications

14. The Care Act facilitates the establishment of the Better Care Fund 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.

RECOMMENDATION

1) That the Health & Wellbeing Board approve the Quarter 3 National Better Care Fund return (shown in Appendix 1) which was submitted to NHS England on 24 January 2020.

Melanie Brooks
Corporate Director: Adult Social Care & Health
Nottinghamshire County Council

For any enquiries about this report please contact:

Paul Brandreth
Better Care Fund Programme Coordinator
Telephone: 0115 97 73856
Email: paul.brandreth@nottscc.gov.uk

Constitutional Comments (CEH 20/02/2020)

15. The Health & Wellbeing Board is the appropriate body to consider the contents of this report.

Financial Comments (OC 19/02/2020)

16. At month 9, the 2019/20 annual BCF Pooled Budget of £92.2m is forecast to break-even.

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: Proposed Allocation of Care Act Funding – report to Adult Social Care and Health Committee on 12 September 2016

- Better Care Fund Performance and 2017/19 Plan – report to Health & Wellbeing Board on 28 June 2017

- Proposals for the Use of the Improved Better Care Fund – report to Adult Social Care and Public Health Committee on 10 July 2017

- Approval for the Use in In-Year Improved Better Care Fund Temporary Funding – report to Adult Social Care and Public Health Committee on 13 November 2017

- Better Care Fund Performance (2017/18) – report to Health & Wellbeing Board on 6 June 2018

- 2018/19 Progress Update and Approval for the Use of the BCF Care Act Allocation (Recurrent and Reserve), the Improved BCF, and the Winter Pressures Grant 2019/20 – report to Health & Wellbeing Board on 6 March 2019

- 2019/20 Better Care Fund Policy Framework, Department of Health & Social Care, 10 April 2019

- Quarterly reporting from Local Authorities to the Department of Health & Social Care in relation to the Better Care Fund, Quarter 4 Return, 18 April 2019

- 2018/19 Better Care Fund Performance – report to Health & Wellbeing Board on 5 June 2019

- Better Care Fund Planning Requirements for 2019-20, Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and NHS England, 18 July 2019

- 2019/20 First Quarter Better Care Fund Performance and Programme Update – report to Health & Wellbeing Board on 4 September 2019

- Retrospective Approval of the 2019-2020 Better Care Fund (BCF) Planning Template Submission – report to Health & Wellbeing Board on 6 November 2019

Electoral Divisions and Members Affected

- All

Appendix 1.

Better Care Fund Template Q3 2019/20

2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 1.1	
Health and Wellbeing Board:	Nottinghamshire
Completed by:	Paul Brandreth
E-mail:	paul.brandreth@nottscc.gov.uk
Contact number:	0115 977 3856
Who signed off the report on behalf of the Health and Wellbeing Board:	Melanie Brooks, Corporate Director, ASC&H Notts CC

Complete

	Pending Fields
2. Cover	0
3. National Condition & s75	0
4. Metrics	0
5. HICM	0
6. Integration Highlights	0
7. WP Grant	0

	Cell Reference	Checker
Health & Wellbeing Board	C19	Yes
Completed by:	C21	Yes
E-mail:	C23	Yes
Contact number:	C25	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C27	Yes
Sheet Complete:		Yes

3. National Conditions

	Cell Reference	Checker
1) Plans to be jointly agreed?	C9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C10	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C11	Yes
4) Managing transfers of care?	C12	Yes
1) Plans to be jointly agreed? If no please detail	D9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D10	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D11	Yes
4) Managing transfers of care? If no please detail	D12	Yes

Sheet Complete:	Yes

4. Metrics

	Cell Reference	Checker
Non-Elective Admissions performance target assessment	D12	Yes
Residential Admissions performance target assessment	D13	Yes
Reablement performance target assessment	D14	Yes
Delayed Transfers of Care performance target assessment	D15	Yes
Non-Elective Admissions challenges and support needs	E12	Yes
Residential Admissions challenges and support needs	E13	Yes
Reablement challenges and support needs	E14	Yes
Delayed Transfers of Care challenges and support needs	E15	Yes
Non-Elective Admissions achievements	F12	Yes
Residential Admissions achievements	F13	Yes

Reablement achievements	F14	Yes
Delayed Transfers of Care achievements	F15	Yes

Sheet Complete:	Yes

5. High Impact Change Model

	Cell Reference	Checker
Chg 1 - Early discharge planning - Q3 19/20 (Current)	D15	Yes
Chg 2 - Systems to monitor patient flow - Q3 19/20 (Current)	D16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Q3 19/20 (Current)	D17	Yes
Chg 4 - Home first/discharge to assess - Q3 19/20 (Current)	D18	Yes
Chg 5 - Seven-day service - Q3 19/20 (Current)	D19	Yes
Chg 6 - Trusted assessors - Q3 19/20 (Current)	D20	Yes
Chg 7 - Focus on choice - Q3 19/20 (Current)	D21	Yes
Chg 8 - Enhancing health in care homes - Q3 19/20 (Current)	D22	Yes
Red Bag Scheme - Q3 19/20 (Current)	D27	Yes
Chg 1 - Early discharge planning - If Q3 19/20 mature or exemplary, Narrative	F15	Yes
Chg 2 - Systems to monitor patient flow - If Q3 19/20 mature or exemplary, Narrative	F16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - If Q3 19/20 mature or exemplary, Narrative	F17	Yes
Chg 4 - Home first/discharge to assess - If Q3 19/20 mature or exemplary, Narrative	F18	Yes
Chg 5 - Seven-day service - If Q3 19/20 mature or exemplary, Narrative	F19	Yes
Chg 6 - Trusted assessors - If Q3 19/20 mature or exemplary, Narrative	F20	Yes
Chg 7 - Focus on choice - If Q3 19/20 mature or exemplary, Narrative	F21	Yes
Chg 8 - Enhancing health in care homes - If Q3 19/20 mature or exemplary, Narrative	F22	Yes
Red Bag Scheme - If Q3 19/20 no plan in place, Narrative	F27	Yes
Chg 1 - Early discharge planning - Challenges and Support needs	G15	Yes
Chg 2 - Systems to monitor patient flow - Challenges and Support needs	G16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Challenges and Support needs	G17	Yes
Chg 4 - Home first/discharge to assess - Challenges and Support needs	G17	Yes
Chg 5 - Seven-day service - Challenges and Support needs	G18	Yes
Chg 6 - Trusted assessors - Challenges and Support needs	G19	Yes
Chg 7 - Focus on choice - Challenges and Support needs	G20	Yes
Chg 8 - Enhancing health in care homes - Challenges and Support needs	G21	Yes

Red Bag Scheme - Challenges and Support needs	G27	Yes
Chg 1 - Early discharge planning - Milestones / impact	H15	Yes
Chg 2 - Systems to monitor patient flow - Milestones / impact	H16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Milestones / impact	H17	Yes
Chg 4 - Home first/discharge to assess - Milestones / impact	H18	Yes
Chg 5 - Seven-day service - Milestones / impact	H19	Yes
Chg 6 - Trusted assessors - Milestones / impact	H20	Yes
Chg 7 - Focus on choice - Milestones / impact	H21	Yes
Chg 8 - Enhancing health in care homes - Milestones / impact	H22	Yes
Red Bag Scheme - Milestones / impact	H27	Yes

Sheet Complete:	Yes

6. Integration Highlights

	Cell Reference	Checker
Integration success story highlight over the past quarter	B10	Yes
Main Scheme/Service type for the integration success story highlight	C13	Yes
Integration success story highlight over the past quarter, if "other" scheme	C14	Yes
Main Enabler for Integration (SCIE Integration Logic Model) for the integration success story highlight	C17	Yes
Integration success story highlight over the past quarter, if "other" integration enabler	C18	Yes

Sheet Complete:	Yes

7. Winter Pressures Grant

	Cell Reference	Checker
Brief narrative on progress in delivering the Winter Pressures Grant spending plan	B8	Yes
Indication whether the planned spend for the Winter Pressures Grant is on track	C10	Yes
Where "NOT ON TRACK", please indicate actions being planned or in place to get back on track	C11	Yes
Have acute hospital trusts continued to be involved in the delivery of the Winter Pressure Grant plan?	C13	Yes
Please describe how this involvement is being ensured	C14	Yes

Sheet Complete:	Yes

Better Care Fund Template Q3 2019/20

3. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Nottinghamshire

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	

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4. Metrics

Selected Health and Wellbeing Board: Nottinghamshire

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	Assessment of progress against the metric plan for the quarter	Challenges and any Support Needs	Achievements
NEA	Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population	Not on track to meet target	SOUTH: At planning stage the main local Acute provider identified a coding and counting change that inflated the 19/20 plan. In-year the expected increase in activity volume has not been seen, resulting in significant underperformance against submitted activity plan volume. MID NOTTS: - Drivers of Demand was a piece of work commissioned by the ICS in response to the growing non-elective demand being seen across Nottinghamshire. - The analysis indicated that there was no single reason for the increasing demand, but that several factors may be contributing to the rising demand. 9 areas were identified and included front door streaming, care home admissions, EMAS non- conveyancing. - Some action plans have been implemented for some of these areas whilst others still need further resources and data before starting.	MID NOTTS: Streaming and Care Homes have shown positive results in a short period of time. SOUTH: Activity below plan.

			NORTH: Bassetlaw Hospital continues to see an increase in A&E attendances and subsequent admissions to hospital this year. The CCG invested considerably for this year's emergency / unplanned activity both in the hospital, to introduce the Call for Care model for Bassetlaw and to utilize health and social care data/predictive analytics tools already used in Mid and South Nottinghamshire. The CCG will continue to work with all partners to try and minimize the increase in activity. At end of November 2019 year-to-date emergency admissions are slightly over plan by 198 admissions (2.1%).	
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Work is underway with partners via the BCF to develop a greater range of housing options and pathways for older adults.	This is slightly above target and the Council is seeing more OA with complex requiring residential/nursing care. The most common age of admission to LTC is 85, and the average length of stay is 2.19 years. Latest benchmarking shows that NCC is performing better than regional and national averages.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	Development of a joint countywide commissioning plan with health and District Councils is required to identify population needs and a more strategic approach to the putting in place the right integrated models to support both admission avoidance and timely discharge.	On track with the Council's strategy, both the number of people receiving reablement on discharge from hospital and the percentage at home 91 days after reablement have increased this year. More people are now receiving reablement in their own home from START and HFRS services.
Delayed Transfers of Care	Average Number of People Delayed in a Transfer of Care per Day (daily delays)	Not on track to meet target	SOUTH: Focus is on delivering the HICM effectively as described in tab 5. MID NOTTS:	Countywide: Positive social care performance has been sustained. SOUTH: Improvements have been

			- HFID will now focus on discharge to assess and non-weight bearing pathways. Full support from SFHFT required to ensure progress. - The "hub" is now stood down from a system perspective but remains in place to serve an internal SFHFT purpose. NORTH: There has been an increase in the number of days delayed in November 2019 to 129 days delayed, with the main increases seen for the Patient / Family Choice reason followed by increases in Housing delays & Care Package in Home Delays. April to November 2019 average days delayed equals to 2.4 days delayed per day, up from 2.2 days delayed per day from April to October.	seen in October and November 2019, however, high performance in the early part of the year may mean it is difficult to get back on target for the remainder of the year. MID-NOTTS: - A weekend discharge pilot has improved the level of discharges over the weekend. - A joint pilot combining the community and acute therapy teams is currently taking place to share learning and improve processes around discharge. - The over 21 and 7-day patient process is fully embedded and has resulted in a reduction in LOS for these cohorts of patients. - Visited Luton & Dunstable (top DTOC performer) to look at opportunities that system partners could adopt to improve timely discharges. NORTH: Bassetlaw Hospital's share of the total DToC position has decreased significantly over the past year. The Integrated Discharge Team will continue to work with County Council colleagues and community care providers to ensure delays are kept to a minimum, and the Bassetlaw Call for Care service went live on the 29th July. Call for Care is the urgent care navigation service commissioned to deliver a two-hour response for people in Bassetlaw to prevent an avoidable hospital admission or

				support timely discharge from the Emergency Department.

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5. High Impact Change Model

Selected Health and Wellbeing Board:	Nottinghamshire

Challenges and Support Needs — Please describe the key challenges faced by your system in the implementation of this change, and Please indicate any support that may help to facilitate or accelerate 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

			Narrative		
		Q3 19/20	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges and any Support Needs	Milestones met during the quarter / Observed impact
Chg 1	**Early discharge planning**	Established		South: There has been an increase in community bed requests and a waiting list for patients that are termed 'enhanced'. Greater focus is required to support P1 (pathway one) - home care and reablement. Mid: SFHFT have been working to embed the Nerve-centre beds e-module. A review of the SFHFT HFID (home first integrated discharge) hub was undertaken, which has identified the	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 delivered weekly. DTOC currently 3.1% and is low in comparison to previous winter months. Average median length of stay post Medically Stable for Discharge @ 1.2days.

				need for a more visible presence on the wards to physically review the patients and identify ones that can be supported via D2A. This review has led to the daily HFID hub being stood down as staff cannot attend both. The workstream is still pursuing how we can support patients with non-health needs and is exploring a pooled budget which can be accessed should patients be delayed in hospital for reasons such as a broken boiler at home. System calls have taken place when the system has experienced pressures and A&E Delivery Board has reviewed performance and flow each month. North: Efficient Phase 2b Interoperability implementation, further development of joint integrated health and social care IT systems. Further integration of other agencies e.g. housing to work in a more integrated way with Social Care and Rapid Response within the Emergency Department. 6-day working practice to be evaluated across DBTH to identify further development e.g. cover of ED on Saturdays.	Joint DTOC coding Standard Operating Procedure continues across all organisations. Front Door Discharge team work holistically (trained through CityCare competencies framework) and refer direct to START - County Social Care Home First Response Service 7-day service to bridge capacity of Homecare and START. Intensive Support at Home pilot commenced 18 November 2019 which provides overnight wrap-around support. 25 High Impact Actions to deliver an Integrated Discharge Function agreed and being implemented by Q4 19/20. This includes enhanced system leadership, streamline discharge and decision processes, review of pathways, workforce and systems. Mid: The Home First Integrated Discharge (HFID) work stream which went live in May 2019 has now focused in on delivering D2A and NWB pathways. On 14/01/20 and 16/01/20 a small MDT made up of Acute and Community therapy along with a social worker will visit Ward 33 rehab ward at KMH and review all patients who have had a LOS of 5 days and use a pull approach to take the patient home where a full assessment of need will be undertaken. For those patients identified as suitable for D2A but can't go home a database of reason for delay will be captured and evaluated to identify gaps. North: Interoperability Phase 2a Implemented, weekly length of stay informs the Long LOS patient tracking list on NHSi, also introduced the Fracture scheme pathway. Call 4 Care service implemented to aid hospital admission avoidance via ED. Social Care staff role now integrated within ED and aligned with Rapid Response worker role.

					6-day working practice now embedded across DBTH. Voluntary sector reps now sit and work alongside the Integrated Discharge Team staff.
Chg 2	**Systems to monitor patient flow**	Established		South: Dashboard and systems to monitor flow in place; currently a manual process across the system. Mid: A key piece of work is the ICS demand & capacity work which has been delayed. Internal bed modelling work has taken place at SFHFT to provide a 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 System OPEL status is monitored daily and a consolidated report is sent out to all system partners and NHSE/I for both information and action. System calls are held every Monday afternoon and further calls are already in place each working day, if required. The latter are cancelled on the day if the System is deemed to not require the call. Social care has produced a demand and capacity function which has allowed the system to have sight of available resource. The system winter plan will become a system seasonal plan, which will account for seasonal fluctuations in demand and capacity which is key to patient flow. North: Increased demand for Intermediate care beds leading to unnecessary DTOC waits. All Intermediate Care referrals now have joint assessment by primary and secondary care to identify Homefirst with the information being captured to influence further development and system capacity needs.	South: All system partners now have access to nerve centre on their laptops via VDI apps, giving staff direct access to NUH data to view and edit. Interoperability project at NUH complete to automate Assessment and Discharge Notices for County Social Care. Plans for City Social Care underway. Care Home Bed capacity system is complete with all care homes signed up through NHS England. Mid: SFHFT have been working to embed the Nerve-centre beds e-module. A review of the SFHFT discharge hub was undertaken, which has identified the need for a more focussed meeting; this will be picked up as part of the HFID project. The work stream has also commenced conversations with Local Authority partners to identify discharge pathways for 'non-health delays' e.g. (hoarding, broken boilers etc) to reduce delays in this area. System calls have taken place when the system has experienced pressures & A&E Delivery Board has reviewed performance and flow each month. North: Regular Trust Flow meetings are held weekly to highlight obstacles and pressures on the system and problem solve. Implementation of Phase2b to aid real time patient updates across DBTH from wards to IDT. Regular attendance at the morning IDT meetings by multiple agencies to aid communication/decision making e.g. MH/LD and NHFT staff and hospital ward staff.

Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established		South: Challenges to maintain the reduction of DSTs in hospital to <15%. Work progressing with stroke to reduce the requests for DSTs and mental health patients. Commissioning decision needed to explore increasing community stroke beds and reduce DTOCs. Implementing D2A into acute mental health wards to support patient flow. Ensuring right services are in place to support stroke patients. Mid: Mid-Notts system partners have refreshed the 19/20 Home First Integrated Discharge and the Integrated Rapid Response Service (IRRS) PIDs. This is where the system partners have agreed to deliver D2A in Q4 and mobilise an integrated rapid response service (IRRS). The IRRS will include community, social care and acute colleagues working in a more integrated way in ED and on the wards. North: Develop greater links with Care homes. Challenge around navigation of housing pathways both council and private and access to temporary accommodation. More integrated working with Housing colleagues to identify gaps in service. Increased level of joint work with Bassetlaw District Council Housing. Use of Assistive technology minor equipment via Bassetlaw District Council to sustain and assist people to avoid hospitalisation.	South: Weekly long patient stay review in place by senior partners. Transfer Action Groups within NUH across the Divisions are in place. Transfer Action groups also in place within community bedded facilities. Main delay reasons reported daily from the acute trust. Mid: Community providers, Social Care and the Acute Trust have come together as an ICP to deliver a single integrated discharge team in ED, community facing admission avoidance and D2A pathways. All partners are now members on the weekly urgent care system call and provide a demand & capacity OPEL dashboard for system visibility. System providers work collaboratively with elements of integration, despite there being no single organisational structure. North: 3rd Sector are now working in a joint approach with Bassetlaw District General Hospital/Integrated Discharge Team, Community Health and Social care to facilitate quality discharge to reduce readmission and reduce the need for statutory services. Introduction of the Therapy Flow Coordinator which further integrates Health & Social Care including working closely with Community colleagues across the patient pathway this includes supporting the coordination of the Intermediate care pathway. Working more closely with Housing around hospital discharges and the use of discharge accommodation.

Chg 4	**Home first/discharge to assess**	Established		South: Increased demand for home care package as part of Home First. National support from team would be welcomed; extended and challenging length of stay for discharge of patients with no recourse to public funding e.g. failed asylum seekers. National staffing shortage for home care and qualified staff. Mid: By utilising ICS transformation funds system partners have been able to strengthen the resource needed to support more people in the community and improve flow within the acute. Within Q4 the Mid Notts system will deliver D2A and provide a community integrated assessment of people in their own home to understand their individual needs. This will follow a personalisation approach to wrap care around people unique to them and away from a hospital setting. D2A pathways were developed by the Alliance (now ICP) partners and approved by Transformation Board and will be implemented in Q4. North: Challenge with capacity within community homebased provider services to provide Homefirst response resulting in patients being transferred to bed based Intermediate care. START service capacity and Home First Response Service capacity and Fracture scheme pathway capacity. Ongoing engagement with stakeholders to review/monitor the pathways.	South: Weekly supported discharge target of 250 has been consistently achieved. Mid: An assessment workshop has been completed with over 20 stakeholders in Nov 2019 which designed the model to deliver D2A agreed next steps. The "hub" is now stood down from a system perspective but remains in place to serve an internal SFHFT purpose. The over 21 and 7-day patient process is fully embedded and has resulted in a reduction in LOS for these cohort of patients. Home First ethos continues to be embedded with supporting materials for setting expectations. North: No DSTs are completed within the hospital setting, assessments are completed via the Short-Term Nursing Beds pathway, beds at external residential settings are funding by the CCG with MDT involvement as part of the assessment process. Intermediate Care and Assessment beds now located at Westwood RH since the closure of another unit. Implementation of the use of an Occupational Therapist within the Home First Response initial discharge package service has reduced ongoing packages of care and in some cases reduced the need for an ongoing POC.
Chg 5	**Seven-day service**	Established		South: Workforce change to support 7-day services. Whilst some services are in place to support 7-day working it is recognised there are gaps. Challenging to provide a 7/7 service across the IDF requires recurrent funding.	South: IDT provide the service 6 days a week (includes Sunday). Home First group looking at how to get to a 7-day integrated discharge function across the system. County Social Care have a rota system in place to cover weekend

				Mid: D2A will be implemented in Q4 which is intended to provide a seven day a week service and support the wards improve advance planning of discharges. The SFHFT discharge policy is in final draft and promotes seven day working in line with community and social weekend services. North: Only able to complete referrals for POC and care home placements over 5 days, so weekend referrals remain a challenge. Acute trust to develop and support 7 day working within the IDT. START service re-design is now underway linked to potential 7-day referral service.	working. Work on-going to develop 7/7 service for IDT in NUH. Business case development to increase IDF (NUH and community providers). Mid: As a system we are already displaying examples of mature & exemplary. Call for Care community service operates over the weekend, along with transport providers, hospital social care teams. This will be further enhanced through the implementation of IRRS and D2A. NORTH: With the introduction of Interoperability Phase 2a function of electronic referrals via the wards and IDT, referrals can now be made to the IDT on a 24-hour, seven day a week basis, which aids the efficacy of response from the IDT. IDT can now refer to other services linked hospital discharge e.g. START and HFRS.
Chg 6	**Trusted assessors**	Established		South: Recruitment challenges in NUH for Trusted Assessor at NUHT. Mid: Within the D2A pathways Mid Notts will promote a Trusted Assessor principle to enable patients to be discharged sooner and not have to wait for multi agencies to visit the patient on the wards. This will be done by SFHFT identifying complex patients who are MFFD and referring into a SPA for D2A. One member of the D2A team will visit the ward and acting on behalf of system partners will discharge the patient where safe to do so for further assessment of their individual needs in their own home. Once this is in place and evaluated then the status will move to 'Mature' or 'Exemplary'. North: Continue to embed the trusted assessor model with local care homes; ongoing presence at the Bassetlaw Care Home forum events. Development ongoing to widen the	South: Trusted Assessment model is being developed as part of the IDF work. Review of Transfer of Care (TOC) underway that will include specifics around 'enhanced' / challenging cohort of patients. Mid: System partners continue to work closely and as collaboratively as possible; all system partners attend the 21 and 7-day LOS meetings. Once the D2A pathways are implemented the Trusted Assessor approach will be fully embedded. North: Bassetlaw hospital IDT operate a trusted assessor model of work using a multi-agency staff group using a single assessment/referral document which is accepted by other community bed-based providers and OOA providers.

				trusted Assessor role with ED across health and social care staff.	
Chg 7	**Focus on choice**	Established		South: Continual support for staff when implementing the discharge policy. Implementation challenges in the community. Continual review and support for staff. Mid: The revised discharge policy is still in final draft and this will need to be embedded for mid-Notts to declare a 'Mature' status. Patient Choice focus & distribution of letters is more robust and promoted by the Integrated Discharge Advisory Team (IDAT) within SFHFT. North: The IDT focus on choice is an integral part of the discharge discussion at all stages, however there is no formal Choice Protocol in place. Patient Choice Protocol is currently being reviewed with plans to approve by both organisations and work across all DBTH sites. This will include letters to be given to patients/relatives with clear guidance regarding expectations for discharge.	South: Review of policy anticipated as part of the IDF work and Excellence and Discharge Programme. Joint approach of social worker and ward staff to implement the policy, reinforcing collective message and consistency. Mid: The SFHFT discharge policy is in final draft form and waiting final sign off and implementation across SFHFT. An STP-wide patient leaflet is distributed to patients upon admission to SFHFT. This enables early discharge conversations and forms the basis on which patient choice conversations will take place moving forwards. It will be supported by the discharge policy and sets patient, family and carers expectations in terms of timeframes /circumstances someone can expect to remain in the Acute Trust. The revised DToC guidance around interim care has been implemented by Mid-Notts partners and a key element of this is the change from Acute Trust attributable DToCs to Social Care attributable DToCs for declined offers of care home placements when home-based POC are not available. This will ensure that the relevant organisation will be able to positively influence the DToC solutions for these patients. North: Within DBTH a Discharge Passport is given to all 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.
Chg 8	**Enhancing health in care homes**	Established		South and Mid: Enhanced Health in Care Homes Framework - priority of National	Mid and South: Implementation progress against the 7 core elements and 18 sub elements of the

				'Ageing Well' programme and NHS Long term plan delivery. Work is underway to understand the system approach to the national Ageing Well programme. This is to ensure appropriate system governance to support the effective delivery of Ageing Well. PCNs identified as the 'drivers' of change through the network contract DES and service specifications are at different levels of maturity and development. There is a risk of overburden/disengagement, delivery of 7 service specification over the next 4-5 years. EHCH delivery in year 2020/21 is reliant upon co-design and delivery with Community Services via NHS standard contract. Consultations ongoing regarding community services contract and service specifications. Final Specs and infrastructure to support delivery expected March 2019 for delivery from April 2020 - limited 'lead in' time. EHCH Draft service specification metrics published by NHSEi are not fully aligned to wider programmes of work, reporting and data collection to evidence complimentary interventions impact. North: The 3 Primary Care Networks in Bassetlaw are at different development stages and as part of this development there is the need for consistent GP links with Bassetlaw care homes to reduce ED presentation/GP appointments, increase and maintain the health and well-being of residents within care homes. Ongoing Development of the links between DBTH and the Primary Care Networks strategy of specific GPs and Community Nursing linked to care homes.	Enhanced Health in Care Homes framework has been benchmarked. Progress is variable but positive when compared regionally and nationally. Ageing Well, including EHCH is included within our Nottingham and Nottinghamshire ICS 5-year strategic plan. North: Bassetlaw CCG holds a care home forum twice yearly to influence and inform care home development, linked to hospital admission avoidance and facilitating hospital discharge.

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.					
		Q3 19/20 (Current)	**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**
UEC	**Red Bag scheme**	Established		Feedback received that: 1) Red bags are not being returned to the Care Homes from the hospital. 2) Care Homes are not using the bags frequently enough. Support is not required at this stage.	South and Mid: - Reinforced lost bag protocol at SFHFT. - Comms planned to re-promote the red bags scheme. - Review of red bags to be undertaken. - Red bag scheme in operation across the South. 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.

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6. Integration Highlight

Selected Health and Wellbeing Board: Nottinghamshire

Remaining Characters:	16,173

Integration success story highlight over the past quarter:

Please give us an example of an integration success story observed over the past quarter. This could highlight system level collaborative approaches, collaborative services/schemes or any work to progress the enablers for integration (as per the SCIE logic model for integrated care). Please include any observed or anticipated impact in this example.

The Nottinghamshire Health and Care Portal is a system designed to improve information sharing across health and care organisations throughout the county. It is a read only view of information held across systems and organisations that allows staff involved in the provision of Direct Care to view other patient data held in another system without needing full access. Information is currently shared into the portal by Nottingham University Hospitals (NUH) Trust, Sherwood Forest Hospitals Trust, Nottinghamshire Healthcare Foundation Trust (Mental Health information only) and GPs from Mid-Notts, South Notts and Nottingham City.
Adult Social Care frontline staff were granted access to this portal and this was launched on 30 August 2019 after extensive training; a total of 625 staff have been formally trained and approximately 880 staff have access to the portal now. We are monitoring usage on a weekly basis to ensure that usage increases, and we share the different ways that staff are using the information, to help others try it out and gain the benefits. By the end of December 35% of ASC staff had used the portal.
Benefits to NCC Service Users:
- Staff have an increased level of knowledge regarding their health needs. The ability to confirm diagnosed conditions, prescribed medication, test results and hospital appointments means staff are better able to allocate care that meets their needs and is at the correct level.
- Cases can be correctly triaged to the correct team when service users are initially referred to NCC. Staff in the Adult Access Service are able to see more information about someone to know what the correct solution for their needs is.
- Access to more information can lead to a quicker progression of cases. Staff frequently comment that it can be frustrating to wait for staff at Health organisations to become available to pass on the correct information which may cause delays. E.g. waiting for GPs to write back with the information for DFG applications.
- NCC staff are likely to have to ask fewer questions of a service user, who will not get as frustrated at having to repeat information which they have already told other professionals involved in their care.

Benefits to NCC Staff
- Staff have increased confidence that they're making correct decisions and that the care they are allocating to a service user is meeting their needs.
- Improved knowledge about a service user helps staff be able to know where to correctly direct them as they know what is suitable.
- Checking the portal in advance of visits, to gather relevant information and check that a social care referral is appropriate, has led to staff finding out that service users have been admitted to hospital or have died. These have prevented wasted visits and awkward conversations.
- Staff can use the portal to check that things they have arranged have been completed correctly. E.g. GP appointments, GP home visits.
- Information that is gathered from the portal that enables time savings includes:
  • GP information – prevents needing to ring GP and wait for them to be available

• Discharge Letters – if patients do not have their discharge letter following a stay in hospital, having access to them in the portal prevents needing to ask multiple questions to find out the information that is included. • Hospital admissions –confirmation of which hospital a person is in, and which ward means quicker locating of someone, and bypassing of hospital admissions lines.

Where this example is relevant to a scheme / service type, please select the main service type alongside or a brief description if this is "Other".	
Scheme/service type	Other (or multiple schemes)
Brief outline if "Other (or multiple schemes)"	The Portal is accessed by all frontline ASC staff whether they work in younger adults or older adults assessment teams, Start Reablement, Notts Enabling Service, Adult Access Service, hospital discharge teams etc. Therefore, the benefits are impacting all services.

Where this example is relevant to progressing a particular Enabler for Integration (from the SCIE Integration Logic Model), please select the main enabler alongside.	
SCIE Enablers list	3. Integrated electronic records and sharing across the system with service users

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7. Winter Pressures Grant

Selected Health and Wellbeing Board:	Nottinghamshire

Please provide a brief narrative on progress made towards delivering the Winter Pressures Grant spending plan (as expressed within the BCF planning template 2019-20)
All of the planned services funded by the WPG are on track to deliver on activity levels and outcomes by year end. This has supported the Council sustaining one of the lowest numbers of social care delayed discharges in the country. The WP plan included an increase in Homefirst Rapid Response Service which supports people home from hospital, additional Social Work and Occupational Therapy staff to support discharge planning (including in Mental Health) and flow through health and social care intermediate care services, additional preventative services based in hospital, as well as additional packages of homecare and residential and nursing care placements.

Please indicate whether the planned spend for the Winter Pressures Grant is on track	On Track

Have local acute hospital trusts continued to be involved in delivery of the Winter Pressures Grant including any changes in the use of the grant as compared to 2018-19?	Yes