Better Care Fund Template Q3 2019/20

1. Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements document for 2019-20 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the Better Care Support Team (BCST) will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCE) prior to publication.

Quarterly reporting for the 'improved Better Care Fund' (iBCF grant) will be required in Q4 19/20 and is not required for the current quarter Q3 19/20.

The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2019/20 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.gov.uk/government/publications/better-care-fund-planning-requirements-for-2019-to-2020

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

4. Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and achievements realised.

As a reminder, if the BCF plans should be referenced as below:
- Residential Admissions and Reablement: BCF metric plans were set out and collected via the BCF Planning Template
- Non Elective Admissions (NEA): The BCF metric plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions at a HWB footprint. These plans were made available to the local areas via the respective Better Care Managers and remain valid. In case a reminder of your BCF NEA plan at HWB level is helpful, please write into your Better Care Manager in the first instance or the inbox below to request them:

england.bettercaresupport@nhs.net
- Delayed Transfers of Care (DToC): The BCF metric ambitions for DToC are nationally set and remain the same as the previous year (2018/19) for 2019/20. The previous year's plans on the link below contain the DTOC ambitions for 2018/19 applicable for 2019/20:
https://www.england.nhs.uk/publication/better-care-fund-2018-19-planning-data/

This sheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:

- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. HICM

The BCF National Condition 4 requires local areas to implement the High Impact Change Model (HICM) for Managing Transfers of Care. This section of the template captures a self-assessment on the current level of implementation, for the reported quarter, and anticipated trajectory for the future quarter, of each of the eight HICM changes and the red-bag scheme along with the corresponding implementation challenges, achievements and support needs.

The maturity levels utilised on the self-assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area
Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

For the purposes of the BCF in 2019/20, local areas set out their plans against the model applicable since 2017/18. Please continue to make assessments against this erstwhile HICM model and any refreshed versions of the HICM will be considered in the future as applicable.

In line with the intent of the published HICM model self-assessment, the self-assessment captured via BCF reporting aims to foster local conversations to help identify actions and adjustments to progress implementation, to understand the area's ambition for progress and, to indicate where implementation progress across the eight changes in an area varies too widely which may constrain the extent of benefit derived from the implementation of the model. As this is a self-assessment, the approaches adopted may diverge considerably from area to area and therefore the application of this information as a comparative indicator of progress between areas bears considerable limitations.

In making the self-assessment, please ensure that a representative range of stakeholders are involved to offer an assessment that is as near enough as possible to the operational reality of the area. The recommended stakeholders include but are not limited to Better Care Managers, BCF leads from CCGs and LAs, local Trusts, Care Sector Regional Leads, A&E Delivery Board representatives, CHIAs and regional ADASS representatives.

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. The AEDB lens is a more representative operational lens to reflect both health and social systems and where there are wide variations in implementation levels between them, making a conservative judgment is advised. Where there are clear disparities in the stage of implementation within an area, the narrative section should be used to briefly indicate this, and the rationale for the recorded assessment agreed by local partners.

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide supporting detail on the features of the initiatives and the actions implemented that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter with any impact observed, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

To better understand the spread and impact of Trusted Assessor schemes, when providing the narrative for “Milestones met during the quarter / Observed impact” please consider including the proportion of care homes within the locality participating in Trusted Assessor schemes. Also, any evaluated impacts noted from active Trusted Assessor schemes (e.g. reduced hospital discharge delays, reduced hospital Length of Stay for patients awaiting care home placements, reduced care home vacancy rates) would be welcome.

Hospital Transfer Protocol (or the Red Bag Scheme):

- The template also collects updates on areas’ implementation of The optional ‘Red Bag’ scheme. Delivery of this scheme is not a requirement of The Better Care Fund, but it has been agreed to collect information on its implementation locally via The BCF quarterly reporting template as a single point of collection.

- 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.
- Where 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.
- Further information on The Red Bag / Hospital Transfer Protocol: The quick guide is available on the link below:
https://www.england.nhs.uk/publication/redbag/

Further guidance is also available on the Kahootz system or on request from the NHS England Hospital to Home team through: england.ohuc@nhs.net

6. Integration Highlights

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service/scheme or approach and the related impact.
Where this success story relates to a particular scheme type (as utilised in BCF planning) please select the scheme type to indicate that or the main scheme type where the narrative relates to multiple services/scheme types or select “Other” to describe the type of service/scheme.

Where the narrative on the integration success story relates to progressing one of the Enablers for Integrated Care, please select the main Enabler from the drop down. SCIE Logic Model for Integrated Care:
https://www.scie.org.uk/integrated-care/measuring-evaluating/logic-model

7. WP Grant

Reporting for Winter Pressures Grant is being collected alongside the BCF in a single mechanism. For this quarter, the reporting is primarily seeking narratives and confirmation on progress against the delivery of the plans set out for the Winter Pressures Grant as part of the BCF planning process.

Better Care Fund Template Q3 2019/20

2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 1.1

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

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

- As in previous quarters, the BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF Grant information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately.

- The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

Health and Wellbeing Board:	Kensington and Chelsea
Completed by:	Ruth Davoll
E-mail:	ruthdavoll@nhs.net

Contact number:	7392316123

Who signed off the report on behalf of the Health and Wellbeing Board:	Cll S Addenbooke

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

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

<< Link to Guidance tab

2. Cover

	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

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	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

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	Cell Reference	Checker
Non-Elective Admissions performance target assesment	D12	Yes
Residential Admissions performance target assesment	D13	Yes
Reablement performance target assesment	D14	Yes
Delayed Transfers of Care performance target assesment	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

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	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

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	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

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	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

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Better Care Fund Template Q3 2019/20

3. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Kensington and Chelsea

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	

Better Care Fund Template Q3 2019/20

4. Metrics

Selected Health and Wellbeing Board: Kensington and Chelsea

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	On track to meet target	none required	Developed and implemented alternative care pathways with NHS 111 and LAS CHUB to CIS rapid response. Have also improved pathways from LAS paramedics to rapid response
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	We continue to monitor each admission very carefully and the teams are committed to people staying safely at home for as long as possible.	Continued rate of admission within target. We are piloting 3 reablement flats available for people to test out more independent living with support following a discharge from hospital
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	Reablement goals are put in place very quickly and the team work towards independence in a very effective manner. Reablement work is increasingly complex in nature as people	People are supported to remain at home for as long as possible Service is performing above target
Delayed Transfers of Care	Average Number of People Delayed in a Transfer of Care per Day (daily delays)	On track to meet target	None required	RBKC currently 29% below (better than) target and is low in acute and non-acute settings. Implemented weekly Diamond calls with senior system partners. Implemented Discharge to Assess with more complex patients being discharged home with overnight care. • x2 Community Interim D2A /bedded rehab MADE events to support flow/discharges through acute trusts • MADE events at CWHT and Imperial. • Utilising void bed capacity in 3 Borough bedded rehab units, • Block commissioning of interim D2A beds to mitigate against loss of interim beds at another unit due to embargo

Better Care Fund Template Q3 2019/20

5. High Impact Change Model

Selected Health and Wellbeing Board: Kensington and Chelsea

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**	Mature	A number of activities are now well established and business as usual: Red / Green days / daily board rounds with matrons in attendance to provide challenge/ nurse led discharge in place/ front door frailty model in place, supported by Home First.	None	Increase number of discharges from frailty ward and Home First achieved through positive relationships.
Chg 2	**Systems to monitor patient flow**	Mature	Daily(winter months) DTOC calls with system partners. Systems well established to monitor pts with LOS > 14 days. Weekly DTOC calls in place with system partners to manage DTOCs within community rehab beds an interim step down (D2A) beds.	None	Recent implementation of Cerner at Chelsea & Westminster Recent implementation of weekly Diamond calls with senior system partners
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Mature	Well established as BAU - complemented by hospital social workers 7 days/week. The NDT includes: VCS (British Red Cross Hospital to Home service), Social Care , acute and community services.	None	N/A
Chg 4	**Home first/discharge to assess**	Mature	Pathways 1 (Home First) and pathway 2 (step down rehab) mature and BAU.Significant increase in referrals into Home First from frailty ward at ChelWest.	Continue to work with acute trusts to change the language on admission so that patients and family expectations are managed and patients will return home when they medically optimised.	Impementation of next phase of pathway 3 - overnightcare pathwat for more complex patients - December 2019
Chg 5	**Seven-day service**	Mature	Acute Trusts (including MH trusts) have weekend board rounds to facilitate discharge , supported by hosiptal social workers 7 day . Community providers are commissioned 7 days / week incuding rapid response (admission avoidance) and Home First. Bi borough have invested in additional reablement capacity over the weekend to support flow	Although the community services and social care deliver 7 day services it remains a challenge for acute trusts to be able to discharge more complex pts over the weekend.	On average 68 pts discharge from Chelsea & Westminster over the weekend
Chg 6	**Trusted assessors**	Established	Trusted assessors now established across all acute sites into the interim step down beds. Trustsed assessor now embedded within Home first for referrals into rebalement.	The challenge will be to roll out the trusted assessor role to all care homes to support timely transfer.	Improved relationships between IDT staff and Care Homes has improved the pathway.
Chg 7	**Focus on choice**	Established	Well established at Chelwest supported by senior officer attendance at DTOC calls.	Include the Choice Policy in patient information on admission	Improved senior officer accountability
Chg 8	**Enhancing health in care homes**	Established	ECH scemes implemented as BAU.	Action plan being implemented to support of recommendations Care Home audit at Chelwest. Plan to monitor through the AEOPs Board .	Audit completed and action plan developed.

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	The Red Bag scheme implemented and recomendations to improve transfer of care for residents continue.	Limited resources for delivery across 3 acute sites. Standard operating procedures were the transfer to hospital and to avoid a failed discharge and readmission.	Minimal impact observed

Better Care Fund Template Q3 2019/20

6. Integration Highlight

Selected Health and Wellbeing Board: Kensington and Chelsea

Remaining Characters:	17,178

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 implementation of an Integrated Health & Social care Discharge to Assess pathway for complex patients with overnight care needs started in November 2019. With a focus on patients who previously were discharged to residential placement or interim beds they are now given the opportunity to return home in order for an assessment of their long-term care needs to be undertaken. This enable patients and families to make informed choices about their long term care needs and where these are best managed. The overnight care pathway provides a multidisciplinary assessment , which starts within 2 hrs of the patient arriving home to ensure that all care needs are being actively managed .The ethos is one of enabling and promoting independence. At present 6 patients have been discharged via this pathway. A robust evaluation process has been implemented to monitor and evaluate progress which includes staff and patient feedback. Direct impact on reducing ELOS and DTOC as assessments are completed at home rather than patients waiting in hospital whilst awaiting placement or DST assessments.

•Additional Reablement provider capacity has been commissioned via current block contract care providers in order to ensure that all patients/hospital discharges with new or increased care needs are offered an opportunity to receive an integrated Reablement/rehabilitative approach to care and maintain as well as promote independence. Commissioning and operational teams are working with care providers to support development of the workforce to apply a positive and enabling approach. Inaugural workshop held in November to set the standards and expectations with positive feedback. Skills/ training audit carried out which will now form the basis for a robust workforce development workshop style programme to maximise independence with our residents.

•Review and updated protocol to maximise use of x2 bedsits and 1 newly refurbished 1 bed flat at an extra sheltered accommodation scheme, where Reablement programme is carried out to facilitate return to own homes or identify a need for extra sheltered environment long-term. This will prevent deconditioning that would otherwise occur if patients were discharged to an interim residential facility

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	Community Based Schemes
Brief outline if "Other (or multiple schemes)"	

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	9. Joint commissioning of health and social care
Brief outline if "Other"	

Better Care Fund Template Q3 2019/20

7. Winter Pressures Grant

Selected Health and Wellbeing Board:	Kensington and Chelsea

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)
The winter programme is in line with the delivery plan and there is emerging evidence showing the impact of schemes for people and the wider system. At the end of quarter 3 there is an expectation that the programmme will spend based on the spending plan.

Please indicate whether the planned spend for the Winter Pressures Grant is on track	On Track
Where "NOT ON TRACK", please indicate actions being planned or in place to get back 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
Where 'No' is selected above, please describe how this involvement is being ensured	