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Committee Agenda
Follow On Agenda

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Title:	**Joint Health & Wellbeing Board**
Meeting Date:	**Thursday 28th March, 2019**
Time:	**4.00 pm**
Venue:	**British Land Offices, York House, 45 Seymour Street, Marble Arch, London, W1H 7LX (3rd Floor, Rooms 3.11 & 3.12)**

Members:

Cllr Heather Acton (Chair)	WCC - Cabinet Member for Family Services and Public Health
Councillor David Lindsay (Chair)	RBKC – Lead Member for Healthy City Living
Cllr Emma Will	RBKC - Lead Member for Families, Children and Schools
Cllr Sarah Addenbrooke	RBKC - Lead Member for Adult Social Care
Cllr Nafsika Butler-Thalassis	WCC - Minority Group
Melissa Caslake	Bi-Borough Children's Services
Olivia Clymer	Healthwatch Westminster
Angeleca Silversides	Healthwatch RBKC
Dr David Finch	NHS England
Jo Ohlson	NHS England North West London
Bernie Flaherty	Bi-Borough Adult Social Care
Houda Al-Sharifi	Interim Director of Public Health
Toby Hyde	Imperial College NHS Trust
Philippa Johnson	Central London Community Healthcare NHS Trust
Dr Andrew Steeden	Chair of West London CCG
Dr Naomi Katz	West London CCG
Detective Inspector Iain Keating	Metropolitan Police
Detective Inspector Seb Adjei-Addoh	Metropolitan Police

Dr Neville Purssell	Central London CCG
Hilary Nightingale	Westminster Community Network
Maria O'Brien	Central and North West London NHS Foundation Trust
Jennifer Travassos	Housing and Regeneration
Angela Spence	Kensington & Chelsea Social Council representative
Iain Cassidy	Open Age representative

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Tristan Fieldsend Committee and Governance Officer.

Tel: 7641 2341; Email: tfieldsend@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law in advance of the meeting please.

FOLLOW ON AGENDA

PART 1 (IN PUBLIC)

11. BETTER CARE FUND UPDATE **(Pages 5 - 26)**

To receive an update from Senel Arkut (Bi-Borough Adult Social Care).

Stuart Love
Chief Executive

Barry Quirk
RB Kensignton & Chelsea
25 March 2019

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	28th March 2019
Classification:	**General Release**
Title:	Better Care Fund Programme 2017/2019 Update
Report of:	Bi-Borough Executive Director of Adult Social Care Managing Director Central London CCG Managing Director West London CCG
Wards Involved:	All
Financial Summary:	Contained in Report
Report Author and Contact Details:	Wayne Haywood whaywood@westminster.gov.uk

1. Executive Summary

1.1. This report outlines progress on the Better Care Fund (BCF) Plan for 2017/19.

1.2. Delivery of the BCF remains an important way in which the Health and Wellbeing Board (HWBB) fulfils its statutory duty to promote integrated ways of working and deliver a more sustainable health and social care system for the future.

1.3. Westminster City Council and the Royal Borough of Kensington & Chelsea continue to work closely in partnership with both Central and West London Clinical Commissioning Groups on successfully delivering the Better Care Fund Plan and vision for integration across both Boroughs.

1.4. Following discussions over the content of the services contained within the minimum CGG contribution due to in year pressures, we now have a jointly developed integration plan for the remainder of 2018/19 which maintains the CCG minimum contribution to the BCF of £19.5m for WCC & £12.9m for RBKC

set out in the national conditions. Out of these totals, £8.2m in WCC and £5.4m in RBKC is the mandated CCG minimum contribution to protect Adult Social Care (ASC). Currently as a system we are considering the best use of the BCF minimum investment in future years. We should be able to provide a verbal update at the next Board.

1.5. Increased levels of demand and complexity in care arrangements shows that there will be continued pressures on budgets going forward. Partners are considering refocussing the BCF to ensure that the CCG minimum contribution is maintained and other joint services are managed under a joint s75 agreement. Officers are currently working on the detail.

2. Key Matters for the Board

2.1. HWBB is asked to note headline information within the body of this report, approve the BCF Q3 return as well as next steps and planning for 2019/20.

2.2 HWBB is asked to note that partners are working on a set of principles setting out the partnership's approach to a streamlined BCF and S75 for 2019/20.

2.3 Further updates on the BCF programme will be presented to HWWB on a quarterly basis, going forward, with the next update scheduled for summer 2019. By when, we would hope to be able to provide details of 19/20 plans for sign-off.

3 Background

Progress against the Plan

3.1 During the third quarter of 2018/19, Westminster City Council and the Royal Borough of Kensington & Chelsea continue to work closely with both Central and West London CCGs to deliver on agreed schemes within its BCF Plan for 2017/19 and build a more integrated, sustainable health and social care system for the future.

3.2 The Community Independence Service (CIS) which remains a joint priority across the partnership continues to play a key role in preventing non-elective admissions and minimising delayed transfers of care. Our reablement offer remains vital to these ambitions.

3.3 A number of other significant service improvements have been achieved since the last update, including system wide changes such as Home First for managing discharges and patient flows from each of our main acute sites (St Mary's & Chelsea Westminster hospitals), allowing up to 25 people a week to have their health and care needs to be assessed at home rather than on hospital wards.

3.4 Other notable improvements include: streamlining community points of access; and targeted improvements to urgent clinical decision making. There has also been a significant drive to embed Rapid Response as a system responder to urgent care needs within the London Ambulance Service.

3.5 We launched the joint 'Big Plan' in November 2018 for people with Learning Disabilities. Our Joint Improvement Plans also include developing a bi-borough MH Hospital Admission Protocol; developing and implementing a robust 'Transforming Care Management Plan'; demand and forecast analysis of the needs of young people in transition; and a Safeguarding & Serious Incident Reporting blue print.

3.6 The last report to the HWBB on Better Care Fund work noted the creation of new Joint Boards for Learning Disabilities and Mental Health. These Boards are now established and fully operational and have provided the opportunity to resolve system wide challenges and develop approaches to joint working resulting in improved outcomes for local people and a more sustainable use of resources.

3.7 The Improved Better Care Fund (iBCF) continues to support achievement against the BCF plan and is fully spent/committed against the 3 conditions for each borough as follows: meeting adult social care needs, reducing pressure on the NHS and ensuring the local provider market is supported. Both Boroughs also continue to implement the High Impact Change Model for managing transfers of care (which includes the Discharge to Assess process) for patients admitted to hospitals in the bi-Borough. There are no major changes to report since the last report.

3.8 We have agreement from main care home providers to establish a trusted assessor model and several assessors now in place. The Red Bag pilot which was due to end in January 2019 continued into March and the end of the evaluation period.

3.9 The CCGs and Local Authorities have agreed the continued joint investment in Mental Health Supported Accommodation in both Westminster and Kensington and Chelsea. The services will be re-commissioned in 2019 following procurement processes (new services start spring/summer 2019). This is a good example of joint investment in a cross-cutting area that supports good joint working and outcomes for the people with MH needs who use these services.

3.10 Following joint work through the summer and autumn of 2018 partners agreed that a number of contracts previously part of BCF Plans would revert to single agency commissioning. This included those s75 contracts funded solely by one partner but managed by another. Work is nearing completion and a number of

contracts will transfer to the commissioners who fund the services from April 2019. In 2019/20, we will continue the review of dementia and carers services in line with the shared dementia strategy.

Metrics

3.11 National performance metrics are reported in the following areas: Non-elective admissions, Admissions to residential and care homes, Delayed Transfers of Care (DToC) and Effectiveness of reablement. The Quarter 3 BCF return is showing the following:

- Non-elective admissions – Admissions have been high throughout the year, with December the best month to date; however, we are behind target.
- Residential Admissions – 'Not on Track'; however, performance is improving.
- DToC – RBKC: well above target (42% above)
- DToC WCC: 'Not on Track' despite improvements in the last Quarter.
- Reablement - We continue to see more people through Reablement each quarter; 'we meet our targets'.

Governance

3.12 We continue to refresh and strengthen partnership relationships within the bi-Borough and the CCGs. Capacity and capability to deliver change at pace to make the best use of core and BCF resources is a key priority. Several project posts have therefore recently been established to focus efforts on ensuring the 2019/20 Plan is on track and tackles the everyday challenges and complexities delivering a programme of this magnitude presents strategically and operationally, and that there are robust arrangements in place for monitoring and reporting.

19/20

3.13 It is confirmed that there will be a BCF for 2019-20 in the NHS Long Term Plan. National guidance for 2019/20 is due out soon, but, in anticipation, we have already started work on our 2019/20 plan in preparation and readiness for formal submission around mid-May. Moreover, from what we do know, the BCF is expected to be similar in nature to previous years, with no significant changes in requirements. All four national conditions are expected to remain, as will the metrics.

4 Options / Considerations

4.1 This report is for the Board to sign off Q3 of the BCF plan.

5 Legal Implications

5.1 Important there is a set of agreed principles for beyond the current plan which expires in March 2019. Consequently, we will be working to an agreed set of principles until the 2019/20 s75 is formally agreed.

6 Financial Implications, Value for Money and Pressures

6.1 Local Authority and CCG partners have indicated that they are minded to reduce funding within the BCF to the minimum level in 2019/20. This means a significant reduction in the joint investments. The CCGs and councils are however committed to maintain joint working and shared investment outside the BCF via s75 arrangements. This approach gives ability to give firm commitment to services in the BCF minimum, whilst encouraging shared review of services within the s75. We aim to change the commissioning responsibilities and achieve efficiencies by remodelling services.

6.2 The Better Care Plan (2018/19) includes joint budgets of £64.023m in Kensington and Chelsea and £75.822m in Westminster. This includes Total Minimum Contributions of £19.5m for WCC and £12.9m for RBKC.

6.3 The financial climate remains challenging going forward. Officers are currently working on the detail to determine any financial implications for local authority or CCG budgets from April 2019. An update on details of 19/20 plans will be provided at a future HWBB.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Wayne Haywood

Email: whaywood@westminster.gov.uk

Appendices: BCF Q3 Returns for WCC and RBKC

Background papers: None

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Better Care Fund Template Q3 2018/19

1. Cover

Version 1.01	

Health and Wellbeing Board:	Kensington and Chelsea
Completed by:	Ruth Davoll
E-mail:	ruthdavoll@nhs.net
Contact number:	
Who signed off the report on behalf of the Health and Wellbeing Board:	Senior Responsible Officers Health and Social Care

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

Complete	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | Local Government Association | NHS England

<< Link to Guidance tab

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget

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	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes

Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics ^^ Link Back to top

	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToC Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToC Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToC Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToC Support Needs	G14	Yes

Sheet Complete:	Yes

4. High Impact Change Model ^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning Q3 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19	F15	Yes
Chg 5 - Seven-day service Q3 18/19	F16	Yes
Chg 6 - Trusted assessors Q3 18/19	F17	Yes
Chg 7 - Focus on choice Q3 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19	F19	Yes
UEC - Red Bag scheme Q3 18/19	F23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	H12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	H13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	H14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	H15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	H16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	H16	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	H17	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	H18	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	H23	Yes
Chg 1 - Early discharge planning Challenges	I12	Yes
Chg 2 - Systems to monitor patient flow Challenges	I13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	I14	Yes
Chg 4 - Home first/discharge to assess Challenges	I15	Yes
Chg 5 - Seven-day service Challenges	I16	Yes
Chg 6 - Trusted assessors Challenges	I17	Yes
Chg 7 - Focus on choice Challenges	I18	Yes
Chg 8 - Enhancing health in care homes Challenges	I19	Yes
UEC - Red Bag Scheme Challenges	I23	Yes
Chg 1 - Early discharge planning Additional achievements	J12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	J14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	J15	Yes
Chg 5 - Seven-day service Additional achievements	J16	Yes
Chg 6 - Trusted assessors Additional achievements	J17	Yes
Chg 7 - Focus on choice Additional achievements	J18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	J19	Yes

UEC - Red Bag Scheme Additional achievements	J23	Yes
Chg 1 - Early discharge planning Support needs	K12	Yes
Chg 2 - Systems to monitor patient flow Support needs	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	K14	Yes
Chg 4 - Home first/discharge to assess Support needs	K15	Yes
Chg 5 - Seven-day service Support needs	K16	Yes
Chg 6 - Trusted assessors Support needs	K17	Yes
Chg 7 - Focus on choice Support needs	K18	Yes
Chg 8 - Enhancing health in care homes Support needs	K19	Yes
UEC - Red Bag Scheme Support needs	K23	Yes

Sheet Complete:	Yes

5. Narrative

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	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

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Better Care Fund Template Q3 2018/19

2. 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	The minimum contribution is agreed however there has been a recent misunderstanding in regard to CIS reablement funding , which is being resolved with the Local Authorities. This element has yet to be agreed financially, although the service remains in place. The minimum contribution will be maintained.
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget

Statement	Response	If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:	If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q3 2018/19

Metrics

Selected Health and Wellbeing Board: Kensington and Chelsea

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Not on track to meet target	NEA data for Q3 not complete as only have data for M1-8 , which indicates that a 3% variance above the target. NEL growth in demand has risen by 4.17% in Q3 compared with the same time last year.This is a broad indicator which encompasses wider activity than just emergency admissions and includes all ages. CIS / RR is mainly focused on reducing NEA for over 75yrs.	Chelsea & Westminster have continued to achieve the A&E standard trajectory for Q3 94.7%. Working across the tri borough to develop a 'decide to admit' model with improved access to senior clinical decision makers including GPs, acute geriatricians and access to same day urgent care	Not required this quarter
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Working to meet target and there are no major challenges	Residential Admissions within target and stable	Not required this quarter
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	In a few cases service users' decline recommendations such as long term care support (due to charging policy) or equipment or falls prevention advice that would improve their safety to remain home longer. There may be an exacerbation of their long term medical needs. We are seeing more service users with multiple co-morbidities, high needs and mental health issues that affect their engagement in reablement. In terms of discharge to assess/home first patients are being discharged when they are medically optimized and potentially not medically fit. This then means service users are starting Reablement not at their optimum for rehabilitation.	With access to health medical record systems we are able to work more collaboratively with health colleagues to ensure service users medical needs are being met and we are able to escalate to necessary community emergency services eg. Rapid response practitioners with a view to hospital admission prevention. We are providing more moving handling equipment that reduces the need for two care workers to have to support the person with transfers. This supports good relationships between person and their care worker and reduces risks i.e. breakdown of care which would enable the person to remain at home longer. We continue to see more people through Reablement each quarter.	Not required this quarter
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	Continuing to work in a challenging environment	RBKC is currently 44% below (better than) target at M1-7. This is primarily been a result of very significant reductions in non - acute (mental health) delays. Regular MADE events over the past 3 mths ,to review DTOCs across acute and community beds, have enabled the system to identify key contributing themes. The main emphasis has been on the implementation of Pathway 3 (complex pts) and discharge home rather than relying on interim bed placements	Not required this quarter

Better Care Fund Template Q2 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Kensington and Chelsea

Challenges — Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact — Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs — Please indicate any support that may better facilitate or accelerate the implementation of this change

		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary' please provide further rationale to support this assessment	Narrative: Challenges	Narrative: Milestones met during the quarter / Observed Impact	Narrative: Support needs
Chg 1	Early discharge planning	Established	Established	Established	Established		* daily board rounds to identify the appropriate D2A pathway. * expected dates of discharge set within 48hrs of admission.	*System wide SOP for DTOCS implemented *EDD is established during admission phase. Acute NHS Trusts are focusing on ensuring this is consistently completed *Multi Agency Discharge Events undertaken *Red and green days established across all acute trusts, supported by daily clinical challenges around the internal delays. Whole system patient flow issues discussed at monthly AE Ops Board. * Discharge to assess pathways 2&3 are in pilot phase.	no support required this quarter
Chg 2	Systems to monitor patient flow	Established	Established	Established	Established		* each trust utilisies their own systems for monitoring patient flow and therefore there isnt an integrated approach within each suite and across the system.	*Electronic daily bed state report sent to all partners daily to show intermediate bedded care capacity across the system , including community and interim beds within Care Homes. * Tri borough Care Homes inputting daily capacity into Care Pulse system (currently at 50% utilisation). *Regular senior led MADE events in place with all system partners to unblock any delays within the system. *Escalation processes in place for delays *Performance dashboards monitoring for effective use of interim and intermediate care beds.	no support required this quarter
Chg 3	Multi disciplinary/multi-agency discharge teams	Established	Established	Established	Mature		*coordinated discharge planning at a trust level. * establishing joint/ pooled funding for care to enable discharge across health & social care	*Integrated discharge team across all sites proactively supporting the implementation of discharge to assess pathways. * IDT teams co located on some sites.	no support required this quarter
Chg 4	Home first/discharge to assess	Established	Established	Established	Established		* Identification of patients remains an issue as referral numbers remain relatively low against a target of 60/week across the system. * Pathway 2- transfers over the weekend remain a challenge. * capacity in rehab beds limited due to high volume of NWB and associated increase LOS. * Pathway 3 - change in culture for the acute trust to move from a bed focused approach to a home first approach for complex patients who require CHC assessment . * Delivery of an ASC pathway for patients who could be managed at home with overnight support.	*Home first (Pathway 1) - assessments for reablement are not undertaken within the acute trust. Patients are discharged home and need for reablement is assessed at home. *Final draft for respecification of intermediate care rehab beds. * Increase in capacity in H&F to support an increase in referrals. *Discharge to Assess pathway 2 pilot started at Chelsea a& westminster and St Mary's on 6 wards in total. * Patients being discharged within 24hrs of referral to pathway 2 beds, when capacity available. *Discharge to Assess Pathway 3 home pilot started at Chelsea & westminster	no support required this quarter
Chg 5	Seven-day service	Mature	Mature	Mature	Mature	7day health & social care hospital discharge teams in place. Access to Dom POC and Home First is accessible 7 days/week	* System awareness of 7 day health and social care capacity to facilaite 7 day discharges. * Poor system awareness of how to access Dom care at the weekend. * Complex Discharge team at Imperial only working 5/7.	* Adult Social Care to ensure 7/7 provision to support front end, middle and back end elements of the acute pathways now embedded as business as usual. *Complex discharge team at Chelsea and Westminster site work 7 days per week with Social workers to identify and progress discharges. * Monthly monitoring of weekend discharges now in place and reported at AE OPs board at CW. * Community team delivering home first as aligned its capacity to support a greater number of discahrges at the weekend.	no support required this quarter
Chg 6	Trusted assessors	Established	Plans in place	Established	Established		* Releasing acute trust staff capacity to fully undertake the role. * Time taken to build the relationship between tha acute trust and care home providers * 7 day transfers from acute trust to Care Homes (existing residents)	* Agreement from main care home providers to establish a trusted assessor model. * Single assessment documentation agreed. * Trusted assessor identified at Chelsea & Westminster for interim step down beds at Farm Lane. * Trusted assessor in place for pathway 2 pilot.	no support required this quarter
Chg 7	Focus on choice	Established	Established	Established	Established		*Early engagement with families *Managing relatives expectations *Consistent approach to implementing NWL Choice Policy. * Cultural change within the acute trusts	*All Trusts in process of implementing patient choice and ensuring written information is given to patients and families at appropriate times. * Identified as a recurrent theme during DTOC calls and MADE has raised its profile across both trusts.	no support required this quarter
Chg 8	Enhancing health in care homes	Established	Established	Established	Established		*GP provision within care homes limiting timely admissions *Avoiding unnecessary admissions *Access to medical support out of hours	*Telemedicine - 3 CCGs continue to promote implementation of the 111*6 line. - Videoconferencing confirm with 2 3B sites. STP to approach additional sites in the 3B (WL). *Red bag pilot is due to end in Jan 2019. An evaluation will be completed by the end of March 19. The Scheme will continue until the March/ end of the evaluation. *RASD training - WL training is completed. CLCH were commissioned to deliver. There was poor uptake despite using an inreach approach. - CL and H&F delivered the training using the H&F GP Federation lead and the CL care home lead	no support required this quarter

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communication at hospital transfer arrangements for social care residents	Challenges	Achievements / Impact	Support needs

UEC	Red Bag scheme	Established	Established	Established	Established		*Multiple hospital providers across the CCGs. * care homes have no contractual obligation to be involved *Limited resources and capacity for delivery	* Red bag pilot - Is due to end in Jan 2019. - An evaluation will be completed by the end of March 19. - The Scheme will continue until the March/ end of the evaluation. - 20/21 care homes participated in the 3B - St Mary's, CXH and CW are engaged and have co-designed a the SOP - a discharge support pack for 3B homes is also available to support successful discharge - training sessions have taken place via the acute leads to wards and therapy teams. - CCG lead have delivered training to 2/3 acute sites. *CareUk and sanctuary care homes are engaged in the 7 day transfer work.	no support required this quarter

Better Care Fund Template Q3 2018/19

5. Narrative

Selected Health and Wellbeing Board: Kensington and Chelsea

Progress against local plan for integration of health and social care — Remaining Characters: 8,639

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Key Changes since last Quarter:

Metrics

• Non elective admissions – remains as Not on Track - Admissions have been high throughout the year with December being the best month, however performance remains behind target and can only be achieved if December performance is maintained over the next 3 month.

• Residential Admissions – changed from On Track to Not on Track. Incorrect reporting from Q1 where this was off track. Since Q1 performance has been improving.

• DToC – remains as Not on Track – DToC have improved in Q3 – further analysis is being completed on this to look at the increases in non-elective admissions to see if there is any impact on increases of DToC .

High Impact Change Model.

No major changes

Narrative

Following the formal move on by the London Borough Hammersmith and Fulham on 1st April 2018, which ended our longstanding three borough arrangements we are still establishing the impact on the bi-borough. As previously identified, the main impact has been on the governance of the programme and the shared management resource. The CCGs have moved away from a lead resource to programme manage our BCF. We have, where possible, incorporated business as usual elements within existing staffing structures. As a short term remedial measure, we have agreed interim support for key elements of the BCF to ensure that we meet the key deliverables of the national requirements such as BCF reporting. The Local Authority has appointed an Interim Director of Health Partnerships across RBKC and WCC, this role will continue to develop the required relationships and support integration with health colleagues. The dedicated delivery boards for our agreed priorities have commenced and have provided increased clarity on shared services and areas where we can improve services. Despite the move to a single borough Hammersmith & Fulham still have a lead CCG Senior Responsible Officer, which is led by the WLCCG Managing Director. The London Borough Hammersmith & Fulham has a permanent Head of Health Partnerships; this role continues to support the development of relationships, support collaborative working and integration with health colleagues and is the Council's lead for continued delivery and development of the Integration and BCF programme.

During the third quarter of 18/19 the tri-borough has continued to deliver against our agreed plan for the Integration and BCF Plan 2017-19. In this quarter Royal Borough Kensington & Chelsea and Westminster City Council have continued to develop the new bi-borough arrangements to deliver the requirements of the BCF plan following the formal end of the three borough BCF plan. Despite the separation we have continued to work collaboratively on the remaining services that will be managed on a three borough basis, these include hospital discharge, Community Independence Service and the placements brokerage services. This has included open and transparent conversations between health and social care to ensure value for money and

Integration success story highlight over the past quarter — Remaining Characters: 17,894

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

The Delayed Transfers of Care (DToC) trajectory for each HWBB area has been subject to local variance against the submitted plan. There is a continued focus and prioritisation of the work streams within the High Impact Change Model with key areas of success which include:

• The implementation of a system wide Standard Operating Procedure (SOP) which describes a common approach and process to managing discharge across the system effectively is ensuring that the appropriate escalation processes are being followed.

• Frequent system wide MADE events, led by senior officers from both health & social care, have enabled the system to identify key DTOC themes. More focus on EDD and delays within community resources has ensured a system wide approach rather than just focusing on delays within the acute trusts.

• Home First (Discharge to Assess Pathway 1) is now embedded across the tri borough supported by additional capacity in Westminster and Hammersmith & Fulham CIS teams. Assessments for reablement have now moved from the hospital setting into the community, as part of the initial assessment process within the first 72hrs.

• Discharge to Assess pathways (Pathway 3) now include discharge home for more complex patients, who require assessment of their long-term care needs. This pathway is supported with fast access to social work assessment, developed for complex patients who are checklist positive to have overnight care at home on discharge.

• Improved processes for discussion of DToCs with St Thomas and Guys Hospital. In St Charles Hospital, we have implemented a successful patient flow management system, also making sure timely and safe discharge of all inpatients from the MH wards. As a result, the number of DToC in RBKC has dramatically reduced. This has been hugely successful. We are now duplicating the same structure and patient flow management in WCC in Gordon hospital. Although it is early days we have started to see the benefits of this.

• Our ambition is to hold system wide MADE events that looks at all DToC regardless of acute or non-acute settings.

Better Care Fund Template Q3 2018/19

1. Cover

Version 1.01

Health and Wellbeing Board:	Westminster
Completed by:	Ruth Davoll
E-mail:	ruthdavoll@nhs.net
Contact number:	
Who signed off the report on behalf of the Health and Wellbeing Board:	Senior Responsible Officers Health and Social Care

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

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | Local Government Association | NHS England

<< Link to Guidance tab

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget

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	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes

Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

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	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToC Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToC Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToC Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToC Support Needs	G14	Yes

Sheet Complete:	Yes

4. High Impact Change Model

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	Cell Reference	Checker
Chg 1 - Early discharge planning Q3 18/19	F12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19	F14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19	F15	Yes
Chg 5 - Seven-day service Q3 18/19	F16	Yes
Chg 6 - Trusted assessors Q3 18/19	F17	Yes
Chg 7 - Focus on choice Q3 18/19	F18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19	F19	Yes
UEC - Red Bag scheme Q3 18/19	F23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	H12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	H13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	H14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	H15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	H16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	H16	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	H17	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	H18	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	H23	Yes
Chg 1 - Early discharge planning Challenges	I12	Yes
Chg 2 - Systems to monitor patient flow Challenges	I13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	I14	Yes
Chg 4 - Home first/discharge to assess Challenges	I15	Yes
Chg 5 - Seven-day service Challenges	I16	Yes
Chg 6 - Trusted assessors Challenges	I17	Yes
Chg 7 - Focus on choice Challenges	I18	Yes
Chg 8 - Enhancing health in care homes Challenges	I19	Yes
UEC - Red Bag Scheme Challenges	I23	Yes
Chg 1 - Early discharge planning Additional achievements	J12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	J14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	J15	Yes
Chg 5 - Seven-day service Additional achievements	J16	Yes
Chg 6 - Trusted assessors Additional achievements	J17	Yes
Chg 7 - Focus on choice Additional achievements	J18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	J19	Yes

UEC - Red Bag Scheme Additional achievements	J23	Yes
Chg 1 - Early discharge planning Support needs	K12	Yes
Chg 2 - Systems to monitor patient flow Support needs	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	K14	Yes
Chg 4 - Home first/discharge to assess Support needs	K15	Yes
Chg 5 - Seven-day service Support needs	K16	Yes
Chg 6 - Trusted assessors Support needs	K17	Yes
Chg 7 - Focus on choice Support needs	K18	Yes
Chg 8 - Enhancing health in care homes Support needs	K19	Yes
UEC - Red Bag Scheme Support needs	K23	Yes

Sheet Complete:	Yes

5. Narrative

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	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

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Better Care Fund Template Q3 2013/14

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board:	Westminster

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	The minimum contribution is agreed however there has been a recent misunderstanding in regard to CIS reablement , which is being resolved with the Local Authorities. This element has yet to be agreed financially, although the service remains in place. The minimum contribution will be maintained.
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget

Statement	Response	If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:	If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)
Have the funds been pooled via a s75 pooled budget?	Yes		

Better Care Fund Template Q3 2018/19

Metrics

Selected Health and Wellbeing Board: Westminster

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Not on track to meet target	NEA data for Q3 not complete as only have data for M1-8 , which indicates that a 6% variance above the target. This is a broad indicator which encompasses wider activity than just emergency admissions and includes all ages. CIS / RR is mainly focused on reducing NEA for over 75yrs.	Working across the tri borough to develop a 'decide to admit' model with improved access to senior clinical decision makers including GPs, acute geriatricians and access to same day urgent care	Not required this quarter
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Residential dementia is in high demand and the reason for residential targets up.	Nursing admissions are stable. The target for overall numbers in registered accommodation was reduced to 210 this year. The numbers in registered accommodation are very very stable over the past 5 years.	Not required this quarter
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	*Increase in more acutely unwell and people with multiple long term conditions being discharged through Home First and ongoing support provided by reablement. This has had an impact on the number of pts being readmitted prior to the end of reablement. * Increase in referrals from the complex care team looking to reduce overall costs and determine if placement is required. This may account for percentage increase as this cohort of people would previously not have been referred to reablement. * Reablement within Westminster continues to be the main team for moving and handling assessments following a change in need sue to our quick response times and flexability. Previously this would have gone	* Continuing to build closer working relationships with other health partners (CLCH neuro team and CIS rehab) to ensure parity of service delivery once rehab has ended. * Working with CIS RR to support patients to remain at home and CIS Home First to facilitate patient flow and discharge. * Looking at SMARTER CARE initiative to reduce double handed to single handed POC , where appropriate releasing significant savings. * Maintianing close links and assisting in service demonstrations with Home care providers to reduce care inefficiencies.	Not required this quarter
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	WCC is currently higher than the annual trajectory at M1-7. There were very significant challenges around delayed days from April 18, particularly in the acute settings (and mostly out of area providers)	*Regular MADE events over the past 3 mths ,to review DTOCs across acute and community beds, have enabled the system to identify key contributing themes. *The main emphasis has been on the implementation of Pathway 3 (complex pts) and discharge home rather than relying on interim bed placements. * Consistent CCG support to UCH DTOCs in addition to existing ASC support.	Not required this quarter

Better Care Fund Template Q3 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Westminster

Challenges — Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact — Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs — Please indicate any support that may better facilitate or accelerate the implementation of this change

	Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If Mature or Exemplary, please provide further rationale to support this assessment	Narrative: Challenges	Narrative: Milestones met during the quarter / Observed Impact	Narrative: Support needs
Chg 1 Early discharge planning	Established	Established	Established	Established		* daily board rounds to identify the appropriate D2A pathway. * expected dates of discharge set within 48hrs of admission.	*System wide SOP for DTOCS implemented *EDD is established during admission phase. Acute NHS Trusts are focusing on ensuring this is consistently completed *Multi Agency Discharge Events undertaken *Red and green days established across all acute trusts, supported by daily clinical challenges around the internal delays. Whole system patient flow issues discussed at monthly AE Ops Board. * Discharge to assess pathways 2&3 are in pilot phase.	no support required this quarter
Chg 2 Systems to monitor patient flow	Established	Established	Established	Established		* each trust utilisies their own systems for monitoring patient flow and therefore there isnt an integrated approach within each suite and across the system.	*Electronic daily bed state report sent to all partners daily to show intermediate bedded care capacity across the system , including community and interim beds within Care Homes. * Tri borough Care Homes inputting daily capacity into Care Pulse system (currently at 50% utilisation). *Regular senior led MADE events in place with all system partners to unblock any delays within the system. *Escalation processes in place for delays *Performance dashboards monitoring for effective use of interim and intermediate care	no support required this quarter
Chg 3 Multi-disciplinary/multi-agency discharge teams	Established	Established	Established	Mature		*coordinated discharge planning at a trust level. * establishing joint/ pooled funding for care to enable discharge across health & social care	*Integrated discharge team across all sites proactively supporting the implementation of discharge to assess pathways, * IDT teams co located on some sites.	no support required this quarter
Chg 4 Home first/discharge to assess	Established	Established	Established	Established		* Identification of patients remains an issue as referral numbers remain relatively low against a target of 60/ week across the system. * Pathway 2- transfers over the weekend remain a challenge. * capacity in rehab beds limited due to high volume of NWB and associated increase LOS. * Pathway 3 – change in culture for the acute trust to move from a bed focused approach to a home first approach for complex patients who require CHC assessment . * Delivery of an ASC pathway for patients who could be managed at home with overnight support.	*Home first (Pathway 1) - assessments for reablement are not undertaken within the acute trust. Patients are discharged home and need for reablement is assessed at home. *Final draft for respecification of Intermediate care rehab beds. * Increase in capacity in H&F to support an increase in referrals. *Discharge to Assess pathway 2 pilot started at Chelsea a& westminster and St Mary's on 6 wards in total. * Patients being discharged within 24hrs of referral to pathway 2 beds, when capacity available. *Discharge to Assess Pathway 3 home pilot started at Chelsea & westminster	no support required this quarter
Chg 5 Seven-day service	Mature	Mature	Mature	Mature	7day health & social care hospital discharge teams in place. Access to Dom POC and Home First is accessible 7 days/week	* System awareness of 7 day health and social care capacity to facilaite 7 day discharges. * Poor system awareness of how to access Dom care at the weekend. * Complex Discharge team at Imperial only working 5/7.	* Adult Social Care to ensure 7/7 provision to support front end, middle and back end elements of the acute pathways now embedded as business as usual. *Complex discharge team at Chelsea and Westminster site work 7 days per week with Social workers to identify and progress discharges. * Monthly monitoring of weekend discharges now in place and reported at AE OPs board at CW. * Community team delivering home first as aligned its capacity to support a greater number of discahrges at the weekend.	no support required this quarter
Chg 6 Trusted assessors	Established	Plans in place	Established	Established		* Releasing acute trust staff capacity to fully undertake the role. * Time taken to build the relationship between tha acute trust and care home providers * 7 day transfers from acute trust to Care Homes (existing residents)	* Agreement from main care home providers to establish a trusted assessor model. * Single assessment documentation agreed. * Trusted assessor identified at Chelsea & Westminster for interim step down beds at Farm Lane. * Trusted assessor in place for pathway 2 pilot.	no support required this quarter
Chg 7 Focus on choice	Established	Established	Established	Established		*Early engagement with families *Managing relatives expectations *Consistent approach to implementing NWL Choice Policy. * Cultural change within the acute trusts	*All Trusts in process of implementing patient choice and ensuring written information is given to patients and families at appropriate times. * Identified as a recurrent theme during DTOC calls and MADE has raised its profile across both trusts.	no support required this quarter
Chg 8 Enhancing health in care homes	Established	Established	Established	Established		*GP provision within care homes limiting timely admissions *Avoiding unnecessary admissions *Access to medical support out of hours	*Telemedicine - 3 CCGs continue to promote implementation of the 111*6 line. - Videoconferencing confirm with 2 3B sites, STP to approach additional sites in the 3B (WL). *Red bag pilot is due to end in Jan 2019. An evaluation will be completed by the end of March 19. The Scheme will continue until the March/ end of the evaluation. *RASD training - WL training is completed. CLCH were commissioned to deliver. There was poor uptake despite using an inreach approach. - CL and H&F delivered the training using the H&F GP Federation lead and the CL care home lead	no support required this quarter

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents	Challenges	Achievements / Impact	Support needs

UEC Red Bag scheme	Established	Established	Established	Established		*Multiple hospital providers across the CCGs. * care homes have no contractual obligation to be involved *Limited resources and capacity for delivery	* Red bag pilot - Is due to end in Jan 2019. - An evaluation will be completed by the end of March 19. - The Scheme will continue until the March/ end of the evaluation. - 20/21 care homes participated in the 3B - St Mary's, CXH and CW are engaged and have co-designed a the SOP - a discharge support pack for 3B homes is also available to support successful discharge - training sessions have taken place via the acute leads to wards and therapy teams. - CCG lead have delivered training to 2/3 acute sites. *CareUk and sanctuary care homes are engaged in the 7 day transfer work.	no support required this quarter

Better Care Fund Template Q3 2018/19

5. Narrative

Selected Health and Wellbeing Board: Westminster

Progress against local plan for integration of health and social care — Remaining Characters: 8,640

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Key Changes since last Quarter:

Metrics

- Non elective admissions – remains as Not on Track - Admissions have been high throughout the year with December being the best month, however performance remains behind target and can only be achieved if December performance is maintained over the next 3 month.
- Residential Admissions – changed from On Track to Not on Track. Incorrect reporting from Q1 where this was off track. Since Q1 performance has been improving.
- DToC – remains as Not on Track – DToC have improved in Q3 – further analysis is being completed on this to look at the increases in non-elective admissions to see if there is any impact on increases of DToC .

High Impact Change Model.

No major changes

Narrative

Following the formal move on by the London Borough Hammersmith and Fulham on 1st April 2018, which ended our longstanding three borough arrangements we are still establishing the impact on the bi-borough. As previously identified, the main impact has been on the governance of the

Integration success story highlight over the past quarter — Remaining Characters: 17,896

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

The Delayed Transfers of Care (DToC) trajectory for each HWBB area has been subject to local variance against the submitted plan. There is a continued focus and prioritisation of the work streams within the High Impact Change Model with key areas of success which include:

- The implementation of a system wide Standard Operating Procedure (SOP) which describes a common approach and process to managing discharge across the system effectively is ensuring that the appropriate escalation processes are being followed.
- Frequent system wide MADE events, led by senior officers from both health & social care, have enabled the system to identify key DTOC themes. More focus on EDD and delays within community resources has ensured a system wide approach rather than just focusing on delays within the acute trusts.
- Home First (Discharge to Assess Pathway 1) is now embedded across the tri borough supported by additional capacity in Westminster and Hammersmith & Fulham CIS teams. Assessments for reablement have now moved from the hospital setting into the community, as part of the initial assessment process within the first 72hrs.
- Discharge to Assess pathways (Pathway 3) now include discharge home for more complex patients, who require assessment of their long-term care needs. This pathway is supported with fast access to social work assessment, developed for complex patients who are checklist positive to have overnight care at home on discharge.
- Improved processes for discussion of DToCs with St Thomas and Guys Hospital. In St Charles Hospital, we have implemented a successful patient flow management system, also making sure timely and safe discharge of all inpatients from the MH wards. As a result, the number of DToC in RBKC has dramatically reduced. This has been hugely successful. We are now duplicating the same structure and patient flow management in WCC in Gordon