Better Care Fund Template Q3 2018/19

1. Cover

Version 1.01

Health and Wellbeing Board:	Kensington and Chelsea
Completed by:	Ruth Davoll
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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

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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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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		

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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	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	Multidisciplinary/multi-agency discharge teams	Established	Established	Established	Mature		*coordimated 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 Westminter 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 for 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

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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.