# Better Care Fund Template Q3 2018/19

## 1. Cover

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|---|
| 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 |

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|---|---|
| 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 |

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| 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 |

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| 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 |

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| 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.<br>The target for overall numbers in registered accommodation was reduced to 210 this year.<br>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.<br>* 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. *<br>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.<br>* Looking at SMARTER CARE initiative to reduce double handed to single handed POC , where appropriate releasing significant savings.<br>* 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.<br>*The main emphasis has been on the implementation of Pathway 3 ( complex pts ) and discharge home rather than relying on interim bed placements.<br>* 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 | 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.<br>* expected dates of discharge set within 48hrs of admission. | *System wide SOP for DTOCS implemented<br>*EDD is established during admission phase. Acute NHS Trusts are focusing on ensuring this is consistently completed *Multi Agency Discharge Events undertaken<br>*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).<br>*Regular senior led MADE events in place with all system partners to unblock any delays within the system.<br>*Escalation processes in place for delays<br>*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.<br>* 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. *<br>Pathway 2- transfers over the weekend remain a challenge. * capacity in rehab beds limited due to high volume of NWB and associated increase LOS.<br>* 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 .<br>* 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.<br>*Final draft for respecification of Intermediate care rehab beds.<br>* Increase in capacity in H&F to support an increase in referrals.<br>*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.<br>*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.<br>* Poor system awareness of how to access Dom care at the weekend.<br>* 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.<br>*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.<br>* 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<br>* 7 day transfers from acute trust to Care Homes ( existing residents) | * Agreement from main care home providers to establish a trusted assessor model.<br>* Single assessment documentation agreed.<br>* Trusted assessor identified at Chelsea & Westminster for interim step down beds at Farm Lane. *<br>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<br>*Managing relatives expectations<br>*Consistent approach to implementing NWL Choice Policy. *<br>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<br>*Avoiding unnecessary admissions<br>*Access to medical support out of hours | *Telemedicine<br>- 3 CCGs continue to promote implementation of the 111*6 line.<br>- Videoconferencing confirm with 2 3B sites. STP to approach additional sites in the 3B (WL).<br>*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.<br>*RASD training<br>- WL training is completed. CLCH were commissioned to deliver. There was poor uptake despite using an inreach approach.<br>- 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<br>- Is due to end in Jan 2019.<br>- An evaluation will be completed by the end of March 19.<br>- The Scheme will continue until the March/ end of the evaluation.<br>- 20/21 care homes participated in the 3B<br>- St Mary's, CXH and CW are engaged and have co-designed a the SOP<br>- a discharge support pack for 3B homes is also available to support successful discharge<br>- training sessions have taken place via the acute leads to wards and therapy teams.<br>- CCG lead have delivered training to 2/3 acute sites.<br>*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