Better Care Fund Template Q1 2018/19

Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements for 2017-19 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)

2) To provide information from local areas on challenges, achievements and support needs in progressing integration and the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform delivery improvements

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

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

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

For 2018-19, reporting on the additional iBCF Grant (from the funding announced in the 2017 Spring Budget) is included in the BCF quarterly reporting as a combined template to streamline the reporting requirements placed on local systems. The BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately. MHCLG aim to publish the additional iBCF information in 2018-19.

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC should be referenced against your current provisional trajectory. Further information on DToC trajectories for 2018-19 will be published shortly.
The progress narrative should be reported against this provisional monthly trajectory as part of the HWB's plan.

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

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

4. High Impact Change Model

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

The maturity levels utilised on the self assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area

Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement

Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

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

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

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

Please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making the HICM self-assessment, which could be useful in informing future design considerations.

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

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

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

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
- Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
- Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.
- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:
https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx
Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

5. Narrative

This section captures information to provide the wider context around health and social integration.
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.

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

6. Additional improved Better Care Fund - Part 1

For 2018-19 the additional iBCF monitoring has been incorporated into the BCF form. The additional iBCF section of this form are on tabs '6. iBCF Part 1' and '7. iBCF Part 2', please fill these sections out if you are responsible for the additional iBCF quarterly monitoring for your organisation, or geographic area.
To reflect this change, and to align with the BCF, data must now be entered on a HWB level.
The iBCF section of the monitoring template covers reporting in relation to the additional iBCF funding announced at spring budget 2017 only.
More specific guidance on individual questions is present on the relevant tabs.

Please find a list of your previous Quarter 4 2017/18 initiatives / projects on tab 'iBCF Q4 1718 Projects'.

Section A: Please ensure that the sum of the percentage figures entered does not exceed 100%. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell.
Section B: Please enter at least one initative / project, but no more than 10. If you are funding more than 10 initiatives / projects, you should list those with the largest size of investment in 2018-19.

7. Additional improved Better Care Fund - Part 2

Section C: The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please could you enter 0 in the appropriate box.
Section D: Please enter at least one metric, but no more than 5.

Better Care Fund Template Q1 2018/19

1. Cover

Version 1.0

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. ***Narrative sections of the reports will not be published.*** *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Shropshire
Completed by:	Penny Bason / Val Banks
E-mail:	penny.bason@shropshire.gov.uk; val.banks@shropshire.gov.uk
Contact number:	1743252767
Who signed off the report on behalf of the Health and Wellbeing Board:	Tanya Miles/ Gail Fortes Mayer

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
6. iBCF Part 1	0
7. iBCF Part 2	0

<< 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

^^ Link Back to top

	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 Q1 18/19	E12	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19	E13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19	E14	Yes
Chg 4 - Home first/discharge to assess Q1 18/19	E15	Yes
Chg 5 - Seven-day service Q1 18/19	E16	Yes
Chg 6 - Trusted assessors Q1 18/19	E17	Yes
Chg 7 - Focus on choice Q1 18/19	E18	Yes
Chg 8 - Enhancing health in care homes Q1 18/19	E19	Yes
UEC - Red Bag scheme Q1 18/19	E23	Yes
Chg 1 - Early discharge planning Q2 18/19 Plan	F12	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19 Plan	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19 Plan	F14	Yes
Chg 4 - Home first/discharge to assess Q2 18/19 Plan	F15	Yes
Chg 5 - Seven-day service Q2 18/19 Plan	F16	Yes
Chg 6 - Trusted assessors Q2 18/19 Plan	F17	Yes
Chg 7 - Focus on choice Q2 18/19 Plan	F18	Yes
Chg 8 - Enhancing health in care homes Q2 18/19 Plan	F19	Yes
UEC - Red Bag scheme Q2 18/19 Plan	F23	Yes
Chg 1 - Early discharge planning Q3 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q3 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q3 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q3 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q3 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	H12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	H13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	H14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	H15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	H16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	H17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	H18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	H19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	H23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	I14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I17	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I18	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I19	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I23	Yes
Chg 1 - Early discharge planning Challenges	J12	Yes
Chg 2 - Systems to monitor patient flow Challenges	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J14	Yes
Chg 4 - Home first/discharge to assess Challenges	J15	Yes
Chg 5 - Seven-day service Challenges	J16	Yes
Chg 6 - Trusted assessors Challenges	J17	Yes
Chg 7 - Focus on choice Challenges	J18	Yes
Chg 8 - Enhancing health in care homes Challenges	J19	Yes
UEC - Red Bag Scheme Challenges	J23	Yes
Chg 1 - Early discharge planning Additional achievements	K12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K15	Yes
Chg 5 - Seven-day service Additional achievements	K16	Yes
Chg 6 - Trusted assessors Additional achievements	K17	Yes
Chg 7 - Focus on choice Additional achievements	K18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K19	Yes
UEC - Red Bag Scheme Additional achievements	K23	Yes
Chg 1 - Early discharge planning Support needs	L12	Yes
Chg 2 - Systems to monitor patient flow Support needs	L13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L14	Yes
Chg 4 - Home first/discharge to assess Support needs	L15	Yes
Chg 5 - Seven-day service Support needs	L16	Yes
Chg 6 - Trusted assessors Support needs	L17	Yes
Chg 7 - Focus on choice Support needs	L18	Yes
Chg 8 - Enhancing health in care homes Support needs	L19	Yes
UEC - Red Bag Scheme Support needs	L23	Yes

Sheet Complete:	Yes

5. Narrative ^^ Link Back to top

	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

6. iBCF Part 1 ^^ Link Back to top

	Cell Reference	Checker
A) a) Meeting adult social care needs	D11	Yes
A) b) Reducing pressures on the NHS	E11	Yes
A) c) Ensuring that the local social care provider market is supported	F11	Yes
Initative 1 - B1: Individual title	C18	Yes
Initative 1 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	C19	Yes
Initative 1 - B3: 2017-18 Project names as provided in the 2017-18 returns.	C21	Yes
Initative 1 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	C22	Yes
Initative 1 - B5: Which of the following categories the initiative / project primarily falls under.	C23	Yes
Initative 1 - B6: If "Other", please specify.	C24	Yes
Initative 1 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	C25	Yes
Initative 1 - B8: Report on progress to date:	C26	Yes
Initative 2 - B1: Individual title	D18	Yes
Initative 2 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	D19	Yes
Initative 2 - B3: 2017-18 Project names as provided in the 2017-18 returns.	D21	Yes
Initative 2 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	D22	Yes
Initative 2 - B5: Which of the following categories the initiative / project primarily falls under.	D23	Yes
Initative 2 - B6: If "Other", please specify.	D24	Yes
Initative 2 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	D25	Yes
Initative 2 - B8: Report on progress to date:	D26	Yes
Initative 3 - B1: Individual title	E18	Yes
Initative 3 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	E19	Yes
Initative 3 - B3: 2017-18 Project names as provided in the 2017-18 returns.	E21	Yes
Initative 3 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	E22	Yes
Initative 3 - B5: Which of the following categories the initiative / project primarily falls under.	E23	Yes
Initative 3 - B6: If "Other", please specify.	E24	Yes
Initative 3 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	E25	Yes
Initative 3 - B8: Report on progress to date:	E26	Yes
Initative 4 - B1: Individual title	F18	Yes
Initative 4 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	F19	Yes
Initative 4 - B3: 2017-18 Project names as provided in the 2017-18 returns.	F21	Yes
Initative 4 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	F22	Yes
Initative 4 - B5: Which of the following categories the initiative / project primarily falls under.	F23	Yes
Initative 4 - B6: If "Other", please specify.	F24	Yes
Initative 4 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	F25	Yes
Initative 4 - B8: Report on progress to date:	F26	Yes
Initative 5 - B1: Individual title	G18	Yes
Initative 5 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	G19	Yes
Initative 5 - B3: 2017-18 Project names as provided in the 2017-18 returns.	G21	Yes
Initative 5 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	G22	Yes
Initative 5 - B5: Which of the following categories the initiative / project primarily falls under.	G23	Yes
Initative 5 - B6: If "Other", please specify.	G24	Yes
Initative 5 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	G25	Yes
Initative 5 - B8: Report on progress to date:	G26	Yes
Initative 6 - B1: Individual title	H18	Yes
Initative 6 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	H19	Yes
Initative 6 - B3: 2017-18 Project names as provided in the 2017-18 returns.	H21	Yes
Initative 6 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	H22	Yes
Initative 6 - B5: Which of the following categories the initiative / project primarily falls under.	H23	Yes
Initative 6 - B6: If "Other", please specify.	H24	Yes
Initative 6 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	H25	Yes
Initative 6 - B8: Report on progress to date:	H26	Yes
Initative 7 - B1: Individual title	I18	Yes
Initative 7 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	I19	Yes
Initative 7 - B3: 2017-18 Project names as provided in the 2017-18 returns.	I21	Yes
Initative 7 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	I22	Yes
Initative 7 - B5: Which of the following categories the initiative / project primarily falls under.	I23	Yes
Initative 7 - B6: If "Other", please specify.	I24	Yes
Initative 7 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	I25	Yes
Initative 7 - B8: Report on progress to date:	I26	Yes
Initative 8 - B1: Individual title	J18	Yes
Initative 8 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	J19	Yes
Initative 8 - B3: 2017-18 Project names as provided in the 2017-18 returns.	J21	Yes
Initative 8 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	J22	Yes
Initative 8 - B5: Which of the following categories the initiative / project primarily falls under.	J23	Yes
Initative 8 - B6: If "Other", please specify.	J24	Yes
Initative 8 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	J25	Yes
Initative 8 - B8: Report on progress to date:	J26	Yes
Initative 9 - B1: Individual title	K18	Yes
Initative 9 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	K19	Yes
Initative 9 - B3: 2017-18 Project names as provided in the 2017-18 returns.	K21	Yes
Initative 9 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	K22	Yes
Initative 9 - B5: Which of the following categories the initiative / project primarily falls under.	K23	Yes
Initative 9 - B6: If "Other", please specify.	K24	Yes
Initative 9 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	K25	Yes
Initative 9 - B8: Report on progress to date:	K26	Yes
Initative 10 - B1: Individual title	L18	Yes
Initative 10 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	L19	Yes
Initative 10 - B3: 2017-18 Project names as provided in the 2017-18 returns.	L21	Yes
Initative 10 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	L22	Yes
Initative 10 - B5: Which of the following categories the initiative / project primarily falls under.	L23	Yes
Initative 10 - B6: If "Other", please specify.	L24	Yes
Initative 10 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	L25	Yes
Initative 10 - B8: Report on progress to date:	L26	Yes

Sheet Complete:	Yes

6. iBCF Part 2

	Cell Reference	Checker
C) a) The number of home care packages provided for the whole of 2018-19	D11	Yes
C) b) The number of hours of home care provided for the whole of 2018-19	E11	Yes
C) c) The number of care home placements for the whole of 2018-19	F11	Yes
D) Metric 1	C18	Yes

Sheet Complete:	Yes

^^ Link Back to top

Better Care Fund Template Q1 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Shropshire

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

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 Q1 2018/19

Metrics

Selected Health and Wellbeing Board: Shropshire

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	On track to meet target	na	after two months we believe we are on target with non-elective admissions April 2766 and May 2812, however final quarterly target to be agreed.	na
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	na	after two months we are better than target	na
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	na	reported in arrears	na
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	na	after two months we are better than target	na

Better Care Fund Template Q1 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Shropshire

Challenges Please describe the key challenges faced by you

Milestones met during the quarter / Observed Impact Please describe the milestones met in the imple

Support Needs Please indicate any support that may better fac

		Maturity Assessment				
		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)
Chg 1	**Early discharge planning**	Established	Established	Established	Established	Mature
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Mature	Mature
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Mature	Mature	Mature	Mature	Mature
Chg 4	**Home first/discharge to assess**	Mature	Mature	Mature	Mature	Mature

Chg 5	**Seven-day service**	Not yet established	Not yet established	Not yet established	Not yet established	Plans in place
Chg 6	**Trusted assessors**	Established	Established	Mature	Mature	Mature
Chg 7	**Focus on choice**	Established	Plans in place	Established	Established	Mature
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Mature	Mature

Hospital Transfer Protocol (or the Red Bag scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') t

		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)
UEC	**Red Bag scheme**	Not yet established	Not yet established	Not yet established	Plans in place	Established

ur system in the implementation of this change
ementation of the change or describe any observed impact of the implemented change
cilitate or accelerate the implementation of this change

Narr	
If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	**Challenges**
	For planned care early discharge planning needs to be part of the GP 5 YFV and system planning - resource to support elements of planned care needs to be found to progress this element of the standard to achieve mature. Workforce challenges and heavy reliance on agency staff restricts provider ability to embed the required systems and processes to support early supported discharge sustainably.
	To achieve Mature status the system Demand and Capacity Modelling needs to be completed. This is work in progress. Key challenge is establishing reliable required data sources which are recognised as accurate and representative by all key partners. There is a commitment from all partners to actively contribute the necessary resource to support the modelling over the coming weeks.
Multidiscipliary teams work together to through the discharge hubs, with morning and afternoon meetings to review the MFFD and allocate actions. Model now moving to the next phase of integrated discharge working with expansion of the membership to include community and mental health.	challenges are being over come by working collaboratively
Achieving targets regarding discharge within 48 hours of completion of the FFA, working to audit 48 hour visit by specialist (social worker or therapist) in the community following discharge. Single assessment document reviewed and confirmed as fit for purpose. Trusted assessor roles in care homes established.	Discharge teams are not receiving the number of completed FFAs per week to achieve the system agreed complex discharge targets. Demand and Capacity modelling outcome will inform whether the target needs to be revised. Early indications from preliminary analysis through the demand and capacity modelling is that there is more potential for patients to go home rather than bed based care. Historic shortage of EMI D2A capacity.

	Workforce challenges, particularly in acute, make establishing 7 day working very challenging. For 7 day working to be effective and value for money all elements of the system need to be able to consistently commit the necessary resource over the 7 day period which is not possible at the present time, nor likely in 2018/19. All providers are committed through the STP Workforce Workstream to develop a sustainable workforce plan. The progression of the Future Fit acute hospitals reconfiguration to implementation will signficantly contribute to an improved workforce position, but is subject to the outcome of the current public consultation which ends in early September 2018.
	challenges are being over come by working collaboratively, governance through the
	Inconsistent policy approach to Patient Choice identified in the system and not in line with national policy.
	Enhanced clinical input into care homes initiatives are in place but require review to determine if expected impact is being achieved and whether more or different is required, there is variation between care homes on flow to the hospital. Timeliness of progressing this work has been challenged due to capacity in the commissioning. Requires a deep dive analysis of care homes data to ensure future plans are targetted for maximum impact.

o enhance communication and information sharing when residents move between ca

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
Shropshire CCG and the Council are currently exploring whether a viable business case can be built for the implementation of this scheme	No identified source of funding

ative	
Milestones met during the quarter / Observed impact	**Support needs**
Work continues in SATH and Shropcom to embed the SAFER/RED2GREEN work practices and to overcome the workforce challenges.	na
Demand and Capacity Modelling framework agreed. Steering Group established and weekly working group meetings with key personnel including business intelligence from all partner organisations diaried. 2 demand and capacity system workshops held.	na
Review of the single assessment document undertaken to confirm fit for purpose. One minute brief on the FFA being included in provider staff briefing in July. Enhanced Integrated Discharge Team model implemented.	na
CCG and Council have plans for the winter to introduce EMI D2A capacity. The outcome of the Demand and Capacity modelling will be a key determinant of setting realistic targets for pathways 1, 2 and 3. Project underway for acute and community therapies to work in a more integrated way which will support acute therapies in reducing potential risk aversion to the home first principle.	na

Work is ongoing by all providers to develop and implement a sustainable workforce plan.	na
Trusted Assessors for Care Homes continue to build the necessary relationships with care homes. Currently undertaking assessments with the care home staff with the aim of building confidence so that the trusted assessor staff can take over this work in Q2.	na
System wide Choice Policy drafted based on the national policy and expected to be signed off by A&E Delivery Board in early August 2018for implementation by all providers. System training workshop for staff involved in implementing the policy being planned for Sept 2018.	na
Care Homes data deep dive analysis completed. Indicates that Shropshire is not an outlier for care home admissions. Has identified a cohort of patients from care homes who attend A&E but are discharged with little or no intervention which will be a key target cohort. The Shropshire Care Closer to Home Transformation Programme continues to gain momentum with plans for Phase 1 case management now nearing sign off for implementation. This approach will also encompass patients in care homes.	na

re settings and hospital.

Achievements / Impact	Support needs
not yet	na

Better Care Fund Template Q1 2018/19

5. Narrative

Selected Health and Wellbeing Board: Shropshire

Remaining Characters:	17,588

Progress against local plan for integration of health and social care

Progress against local plan for integration

Prevention:

• Good progress in developing care navigation including social prescribing, integrating delivery with social care Let's talk local, and primary care community care coordinators, and the voluntary sector. Key milestones include:

o Delivery in 14 GP practices (summer 2018)

o Developing system MECC Plus training that links system providers from prevention through to acute (autumn 2018)

o Developing children and young people's scheme (q3 18/19)

• Good progress in developing and delivering an improved Enable service including:

o New advisors in post (autumn 2018)

o Experts by experience (summer 2018)

o Improved connectivity with the mental health trust (ongoing)

• Good progress in developing System Prevention contracts with the Voluntary and Community Sector. Specifications will be developed and tendered by autumn 2018. The contracts will support:

o STP Care Closer to Home

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.

Remaining Characters:	16,432

Integration success story highlight over the past quarter

We have been successful in securing additional funds to support an improved IPS service that will double the number of people in secondary mental health services accessing support into employment. The improved scheme will have a partnership manager, who will improve integrated working and provide training opportunities for the mental health trust, local voluntary and community services and the IPS service. The post will also be charged with developing an integrated employment pathway for all people with mental health issues.

Below please find an IPS case study

Enable IPS Success Story - John

John is a young man, living in a remote rural location, wanting to work, with little direction and seemingly difficult barriers to employment.

Barriers - John has Asperger's and as a result has to manage a diagnosis of high anxiety. John has specific needs associated to his Asperger's, for instance if his routine is disturbed it causes distress so requires time to process any change. When I first met John he was very anxious at the thought of work, and had negative associations with previous work. Whilst his potential was apparent, he could not cope with lots of people around him. He found it difficult to communicate with strangers and his confidence was low.

Direction - Through discussion we identified his own needs from any potential employment. John has a good eye for detail and is very methodical. We matched this with his interests; John has an interest in motor vehicles (he had tried to study motor vehicle repair at college but did not cope with other students not taking their studies seriously and had to leave). We explored this further and John decided his real interest was in auto body repair

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.

Better Care Fund Template Q1 2018/19

Additional improved Better Care Fund - Part 1

Selected Health and Wellbeing Board:	Shropshire
Additional improved Better Care Fund Allocation for 2018/19:	£ 3,959,448

Section A

What proportion of your additional iBCF funding for 2018-19 are you allocating towards each of the three purposes of the funding?	a) Meeting adult social care needs	b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready	c) Ensuring that the local social care provider market is supported
Please enter the amount you have designated for each purpose as **a percentage of the total additional iBCF funding you have been allocated for the whole of 2018-19.** If the expenditure covers more than one purpose, please categorise it according to the primary purpose. **Please ensure that the sum of the percentage figures entered does not exceed 100%. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell.**	38%	57%	5%

Section B

What initiatives / projects will your additional iBCF funding be used to support in 2018-19?	Initiative/Project 1	Initiative/Project 2	Initiative/Project 3	Initiative/Project 4
B1) Provide individual titles for no more than 10 initiative / projects. If you are funding more than 10 initiatives / projects, you should list those with the largest size of investment in 2018-19. Please do not use more than 150 characters.	Continuation	Continuation	Continuation	Maintain existing preventative services that would not otherwise be able to be supported due to budget pressures within the
B2) Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19? Use the drop-down menu, options below: Continuation New initiative/project	Continuation	Continuation	Continuation	New initiative/project
Click here for a reminder of initative / project titles submitted in Quarter 4 2017/18				
B3) If you have answered question B2 with "Continuation" please provide the name of the project as provided in the 2017-18 returns. See the link above for a reminder of the initiative / project titles submitted in Q4 2017-18. Please do not select the same project title more than once.	Procure 20 additional discharge to assess beds in the local community	Increase in Hospital (ICS) social work capacity	By providing support through out the night people are enabled to remain living in their own homes and can be supported to return home from hospital in a more timely way. This service can also respond to emergency situations through the night and should avoid hospital admissions.	

B4) If this is a "New Initative / Project" for 2018/19, briefly describe the key objectives / expected outcomes. Please do not use more than 250 characters.				To prevent the loss of independence by enabling individuals to access services to meet their
B5) Use the drop-down menu provided or type in one of the categories listed to indicate which of the following categories the initiative / project primarily falls under. Hover over this cell to view the comment box for the list of categories if drop-down options are not visible.	3. DTOC: Reducing delayed transfers of care	3. DTOC: Reducing delayed transfers of care	2. Expenditure to improve efficiency in process or delivery	11. Prevention
B6) If you have answered question B5 with "Other", please specify. Please do not use more than 50 characters.				
B7) What is the planned total duration of each initiative/project? Use the drop-down menu, options below. For continuing projects, you should also include running time before 2018/19. 1) Less than 6 months 2) Between 6 months and 1 year 3) From 1 year up to 2 years 4) 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer
B8) Use the drop-down options provided or type in one of the following options to report on progress to date: 1) Planning stage 2) In progress: no results yet 3) In progress: showing results 4) Completed	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results

Initiative/Project 5	Initiative/Project 6	Initiative/Project 7	Initiative/Project 8	Initiative/Project 9	Initiative/Project 10
Continuation	Continuation	Continuation	Continuation	Continuation	Continuation
Continuation	Continuation	Continuation	Continuation	Continuation	Continuation

Review current service offer to ensure effective use of available resource and ensure a responsive reflexive service is available to meet demand in reablement, AA and crisis work with an appropriately trained staff team	Employ 4 trusted assessors through a 3rd party on behalf of the residential and nursing care providers	Mental Health Prevention	Increase the number of practitioner staffing resource within Adult Social Care community teams by 6 assessment staff	To secure 4 extra care units in Shrewsbury to be used as reablement support in the community following hospital admission for those individuals who are not ready to return home, but do not require the level of support offered by the step down beds. These properties can be used for individuals and their carers to move into together	Recruitment of 3 dedicated Social Workers who will solely focus on completion of Continuing Healthcare assessments/MDT's outside the hospital whilst ensuring that people are appropriately and correctly jointly assessed with regard to CHC eligibility where applies.

3. DTOC: Reducing delayed transfers of care	3. DTOC: Reducing delayed transfers of care	9. NHS: Reducing pressure on the NHS	1. Capacity: Increasing capacity	3. DTOC: Reducing delayed transfers of care	9. NHS: Reducing pressure on the NHS
4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer
3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results

Better Care Fund Template Q1 2018/19

Additional improved Better Care Fund - Part 2

Selected Health and Wellbeing Board:
Additional improved Better Fund Allocation for 2018/19:

Section C

What impact does the additional iBCF funding you have been allocated for 2018-19 have	
	a) The number of home care packages provided for the whole of 2018-19:
C1) Provide figures on the planned number of home care packages, hours of home care and number of care home placements you are purchasing/providing as a direct result of your additional iBCF funding allocation for 2018-19. The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please could you enter 0 in the appropriate box.	5,525

Section D

Indicate no more than five key metrics you will use to assess your performance.		
	Metric 1	**Metric 2**
D1) Provide a list of up to 5 metrics you are measuring yourself against. Please do not use more than 100 characters.	Reduction in Delayed Transfers of Care	Increase in number of people discharged from hospital within 48 hours

Shropshire	
£	3,959,448

on the plans you have made for the following:	
b) The number of hours of home care provided for the whole of 2018-19:	**c) The number of care home placements for the whole of 2018-19:**
16,424	204

Metric 3	**Metric 4**	**Metric 5**
Reduction in hospital re-admission	Increase in Admission Avoidance	Reduction in Long Term Admissions to Residential Care

Better Care Fund Template Q1 2018/19

Additional iBCF Q4 2017/18 Project Titles

Selected Health and Wellbeing Board: Shropshire

<< Link to 6. iBCF Part 1

Quarter 4 2017/18 Submitted Project Titles

Project information not submitted in 2017-18 reporting

Project Title 1	Project Title 2	Project Title 3	Project Title 4
Increase the number of practitioner staffing resource within Adult Social Care community teams by 6 assessment staff	Effective discharge of patients from hospital with required equipment identified through an assessment in a timely manner.	By providing support through out the night people are enabled to remain living in their own homes and can be supported to return home from hospital in a more timely way. This service can also respond to emergency situations through the night and should avoid hospital admissions.	Telecare Pilot in regard to Hospital Discharge and Admission Avoidance

Project Title 16	Project Title 17	Project Title 18	Project Title 19
Commission additional emergency Admission Avoidance support in the community through Carer's Trust For All. They will provide emergency only domiciliary care support for the out of hours period. This support is not planned support but designed to be available for urgent situations dealt with by ICS and EDT. Carers Trust 4 All will have access to assistive technology to use in these situations and the pilot will test the use of this equipment in more urgent situations.	Admission Avoidance initiative - Redwoods psychiatric unit	Section 117 discharge planning initiative - Redwoods Psychiatric unit	Carers support offered following the discharge of the person being supported so the carer can receive focussed support for their role in period when they may be anxious or the cared for person may require more support.

Project Title 5	Project Title 6	Project Title 7	Project Title 8
Development of Let's talk across the county so they are inclusive of a range of services. Default position of all customers are offered appointments unless there are specific reasons a home based assessed is required.	7 Day support provided by Shropshire Council Brokerage Service	Recruitment of 3 dedicated Social Workers who will solely focus on completion of Continuing Healthcare assessments/MDT's outside the hospital whilst ensuring that people are appropriately and correctly jointly assessed with regard to CHC eligibility where applies.	OT support and assessment to work with individuals while in the beds to include the transition to their own homes.

Project Title 20	Project Title 21	Project Title 22	Project Title 23
Carers are a vital part of many plans to assist people to return home but currently they are not always provided with support or carers assessments. This post will ensure they are seen as a vital part of discharge pathways including 'Let's Talk Local' hubs within the hospital around visiting times so carers, friends, relatives can assess information and advice.	To secure 4 extra care units in Shrewsbury to be used as reablement support in the community following hospital admission for those individuals who are not ready to return home, but do not require the level of support offered by the step down beds. These properties can be used for individuals and their carers to move into together	To Employ a specialist commissioner to work with the CCG to recommission equipment services	To develop the collection, collation and analysis of data related to informing understanding of the causes of unplanned admissions and delayed transfers of care, action planning and the measurement and evidencing of the impact of initiatives.

Project Title 9	Project Title 10	Project Title 11	Project Title 12
Appointment of a PDU Officer (Complex Care)who will focus on the training needs of staff within Integrated Care Services and support development of professional practice. Will hold specialist practice skills but not be constrained by case holder responsibilities.	Mental Health Prevention	Different Conversations, better Outcomes multi-agency, multi-disciplinary training programme	Procure 20 additional discharge to assess beds in the local community

Project Title 24	Project Title 25	Project Title 26	Project Title 27
Triage so an appropriate response is the outcome not as current there is an increased risk of admission if the person is older.	NHS colleagues have developed a frailty pathway that is in place for older people in hospital and community. There is a MDT hospital based team working with older people through out the health economy which these posts will be part of so social care is an integrated element of the MDT.	Commission Shropshire Partners In Care to develop a care hub, a single point of entry into the care market in Shropshire. This will include the delivery of core training through a skills hub. To also commission them to support providers to improve their information governance arrangements to develop secure information sharing between health, LA and providers	Employ 4 trusted assessors through a 3rd party on behalf of the residential and nursing care providers

Project Title 13	Project Title 14	Project Title 15
Review current service offer to ensure effective use of available resource and ensure a responsive reflexive service is available to meet demand in reablement, AA and crisis work with an appropriately trained staff team	Increase in Hospital (ICS) social work capacity	Falls Prevention

Project Title 28	Project Title 29	Project Title 30
Two providers offering a flexible available care service up to 70 hours brokered direct from ICS which the provider will coordinate what care they need to supply to the discharged person is so they are not time/task specific, the provider will coordinate what they do when during the day. This is not including night cover.	24/7 D2A at Home starting 4/9/17. We have commissioned a provider from 9am on 4/9/17 to 10pm on 29/9/17 to provide home assessment care 24/7 so to avoid people moving straight to placements. This may be for 24 hours or up to 5 days in their own home while the social care worker is assessing and arranging what if any support if required longer term. This to be a fast paced service so as soon as longer term needs or goals are achieved or where longer term services are identified as required the person will transfer to conventional	