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.

Quarterly reporting for the 'improved Better Care Fund' (iBCF grant) will be required in Q4 18/19 and is not required for the current quarter Q3 18/19.

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.

3. When submitting your template, please also copy in your Better Care Manager.

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 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.

Better Care Fund Template Q3 2018/19

1. Cover

Version 1.01

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
E-mail:	penny.bason@shropshire.gov.uk
Contact number:	07143 252767
Who signed off the report on behalf of the Health and Wellbeing Board:	Lee Chapman - Chair

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

Complete

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

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS England

<< Link to Guidance tab

1. Cover

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

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget   ^^ 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

	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

	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

	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

Better Care Fund Template Q3 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 Q3 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	Not on track to meet target	This is a particular focus for neighbourhood/ out of hospital working and this is the first time in recent years that this target has not been met. Additional work needs to be undertaken to	June - 2,684, July 2,804, August 2,766, Sept 2756, Oct 2,921	none at this time
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Shropshire Council has migrated from Care First to Liquid Logic and there is a delay in reporting for December - March	Residential Admissions to end of Q2 – the rate per 100,000 is 185.5 better than the target of 300, figure to end of November 256.5, target for end Q3 is 450	none at this time
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	Figures for Q2 will be published end of Jan and figures for Q3 will be end March and so on. However, we believe we are on track to meet target.	The reablement figure for q1 stands at 83.4%, better than the target of 82%. This covers those patients discharged into re-ablement during April – June with the 91 day follow-up occurring during July –	none at this time
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	On track to meet target	Figures not yet available for all of Quarter 3.	The delayed transfer measure – continues to demonstrate positive results across health and care. Care sustaining low delayed rates since 17/18	none at this time

Selected Health and Wellbeing Board: Shropshire

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)	Narrative			
						If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Established	Established	Mature		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.	Work continues in SATH and Shropcom to embed the SAFER/RED2GREEN work practices and to overcome the workforce challenges.	not at this time
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	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.	Embedded case check challenge, SAFER bundle, RED2GREEN, End PJ paralysis, creating improvements, Made event and Check Chase Callenge demonstrating impact, and length of stay reducing	not at this time
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Mature	Mature	Mature	Mature	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.	out of hospital work needs to bed in and link to 7 day working, for further fulfilment of this high impact change - to move to exemplary	Embedded IDT implementation including daily and weekly targets of complex discharge cases; FFAs completed within 24 hours as required; Enhanced Integrated Discharge Team model implemented.	not at this time
Chg 4	**Home first/discharge to assess**	Mature	Mature	Mature	Mature	chieving 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.	out of hospital work needs to bed in and link to 7 day working, for further fulfilment of this high impact change - to move to exemplary	consistent desired ratio splits of 60%P1, 30% P2, 10% P1	not at this time
Chg 5	**Seven-day service**	Not yet established	Not yet established	Plans in place	Plans in place		7 day availability of GP appointments has been established. However, 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.	Future Fit consultation completed September 2018 and we are awaiting feedback. In the meantime the SaTH Board has agreed to close A&E overnight and plans are currenlty being developed to ensure this is done safely	not at this time

		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Planned)		Challenges	Achievements / Impact	Support needs
Chg 6	Trusted assessors	Established	Mature	Mature	Mature	Integrated assessment tesams work together appropriately; resources are accessed by a singel assessment; confidence and trust increaseing across organisations	challenges are being over come by working collaboratively, governance through the discharge to assess working group	Trusted Assessors for Care Homes continue to build the necessary relationships with care homes.	not at this time
Chg 7	Focus on choice	Plans in place	Established	Established	Established		Challenges will be worked through the A&E delivery group	System wide Choice Policy agreed at A&E Delivery Board in early August 2018 for implementation by all providers. System training underway to implement the agreed policy	not at this time
Chg 8	Enhancing health in care homes	Established	Established	Established	Mature	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.		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.	not at this time

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	Not yet established	Not yet established	Plans in place	Established		n/a	We have taken learning from elsewhere including the T&W Care Home MDT and other national pilots to develop joint working and a specification for delivering the Red Bag in Shropshire in partnership with the Community Trust and SPIC. The programme will be launched in January 19 for one year pilot in a minimum of 8 care homes.	not at this time

Selected Health and Wellbeing Board: | Shropshire

| Remaining Characters: | 16,827 |

Progress against local plan for integration of health and social care

Progress against local plan for integration
Programme office for the STP now supporting the Better Care Fund management in order to fully connect programmes across the area.
The STP ensures that the BCF High Impact Changes across T&W and Shropshire are considered collectively through the Frailty Board.
An updated Partnership Agreement (section 75) has been signed and will form the basis for more pooled arrangements between health and care. Key areas of development will include the risk sharing agreement as joint working progresses and pooling budgets supports system working.
Prevention:
• Connecting STP Population Health strategic planning (national tools and resources – flatpack) and the HWBB/ BCF prevention work.
• 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 (from summer 2018)
o Delivering system MECC Plus training that links system providers from prevention through to acute (autumn 2018)
o Developing children and young people's scheme – still in the planning stage – but has been delayed
• Good progress in developing and delivering an improved IPS Enable service including:
o New advisors in post (from September 2018)

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: | 18,542 |

Integration success story highlight over the past quarter

The Integrated Community Services (ICS) team, jointly run by Shropshire Council and Shropshire Community Health NHS Trust, were named the winner of the Team of the Year, Adult Services award at the national event which took place on Friday 30 November 2018 in London.
ICS provides short-term support for patients who are ready to leave hospital. This involves a team of carers, nurses, occupational therapists and physiotherapists working with the person to help them regain their skills and independence. This will usually be in their own home or as close to home as possible.
ICS teams also work closely with partner organisations to identify people who need support to avoid an admission to hospital in the first place. The team of almost 70 provides a 'Discharge to Assess' and 'Admission Avoidance' service to two acute hospitals, five community hospitals and in community settings.
Early in 2017 Shropshire Council was set extremely rigorous performance targets by the Department of Health and was required to improve its Delayed Transfer of Care (DTOC) performance by 60% by September 2017. By collectively implementing innovative measures, ICS significantly exceeded its target, by achieving a 75% improvement by September 2017, and a 97% reduction in delayed transfers of care between May 2017 and May 2018.
The judges praised each member of the team for being highly motivated and committed and displaying "compassion and values on a daily basis".

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.