# Better Care Fund Template Q2 2017/18

**Guidance**

**Overview**

The Better Care Fund (BCF) quarterly monitoring template is used to ensure that Health and Wellbeing Board areas continue to meet the requirements of the BCF over the lifetime of their plan and enable areas to provide insight on health and social integration.

The local governance mechanism for the BCF is the Health and Wellbeing Board, which should sign off the report or make appropriate arrangements to delegate this.

**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 cell

**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.

If required, the row heights can be adjusted to fit and view text more comfortably for the cells that require narrative information. Please note that the column widths are not flexible.

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 (hyperlinked) 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.pd
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 onfirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflatior
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 17/19, 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 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
- DToC: The BCF plan targets for DToC for the current year 17/18 should be referenced against the agreed trajectory submitted on the separate DToC monthly collection template for 17/18.
The progress narrative should be reported against this agreed monthly trajectory as part of the HWB's plan

When providing the narrative on challenges and achievements, 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 areas to implement the High Impact Change Model for Managing Transfer of Care. Please identify your local system's current level of maturity for each of the eight change areas for the reported quarter and the planned / expected level of maturity for the subsequent quarters in this year.

The maturity levels utilised are the ones described in the High Impact Changes Model (link below) and an explanation for each 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 geograph
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcome
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvemen
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvemen
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-mode

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide further detail on the initiatives implemented and related actions 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 and any impact to highlight, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

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 is currently in draft format. Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team. 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 Q2 2017/18

**1. Cover**

| Version 1 |
|---|

***Please Note:***

***- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.***

***- Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".***

***- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.***

***- 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:** | Birmingham |
| **Completed by:** | Perminder Paul |
| **E-mail:** | perminderpaul@nhs.net |
| **Contact number:** | 07971 773 906 |
| **Who signed off the report on behalf of the Health and Wellbeing Board:** | |

**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'**

**Please go to the Checklist for further details on incomplete fields - Click for link**

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

# Better Care Fund Template Q2 2017/18

**2. National Conditions & s75 Pooled Budget**

Selected Health and Well Being Board: Birmingham

| Confirmation of National 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 Q2 2017/18

**3. Metrics**

Selected Health and Well Being Board: Birmingham

| 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 | Uncertainty about status of BCF and iBCF plans has created difficulties in some stages of implementation. This is set against a background of change created by a system wide Health and social care restructure which presents challenges as well as opportunities | This relates to Birmingham Cross City, Birmingham South Central and West Birmingham non elective admissions. There is some variation between CCG's but good performance by West Birmingham has contributed to improved achievement across the area.<br><br>Collaborative working<br>Reducing the number of non—elective admissions requires effective collaboration across health and care systems to support people in managing conditions and reducing the frequency and necessity for emergency admissions. This presents challenges and whilst a key focus of work being undertaken in the system diagnostic work by Newton (as part of BCF) is on delayed transfers of care it is also 'looking closely at variations in admission rates and services following attendance at the Emergency Department (ED), the reasons for this variation and therefore the | N/a |
| **Res Admissions** | Rate of permanent admissions to residential care per 100,000 population (65+) | On track to meet target | n/a | Cluster / prevalence<br>In the 12 months up to September 2017, 626 clients aged 65+ were admitted into permanent accommodation – down from 764 in the 12 months up to September 16 and in line with the target of 650 included in the BCF plan.<br><br>Previous achievement<br>Birmingham has performed well against this target in previous years and has adopted a cautious approach in 17/18 to maintaining reductions whilst working to manage and reduce their impact on community and home care services. Some commissioning of long term beds has taken place focussing on providing beds for those with the most complex needs including dementia.<br>Mobilisation of new beds from November 2017 onwards<br><br>Interim Beds<br>Additional interim beds have been commissioned by including 'spot' | n/a |
| **Reablement** | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Not on track to meet target | Uncertainty about status of BCF and iBCF plans has created difficulties in some stages of implementation. This is set against a background of change created by a system wide Health and social care restructure which presents challenges as well as opportunities | The data relates to the 2016-17 SALT return which looks at discharges between 1/10/16 and 31/12/16. This shows 730 discharges to rehabilitation of clients aged 65+, with the intention of them returning home, in the period. Of these 566 were still at home 91 days later, giving a proportion of 77.5% .<br><br>System Diagnostic:<br>As above, work around Enhanced Assessment Beds is ongoing as part of the system diagnostic work and it is planned that any major reconfiguration of provision will only take place after that is concluded. This work will also impact on other parts of the reablement/ rehabilitation pathways.<br>System diagnostic – to be completed December 2017<br><br>Home from Hospital services<br>Other work to support this metric | Support is being provided through the system diagnostic workstream. |
| **Delayed Transfers of Care*** | Delayed Transfers of Care (delayed days) | Not on track to meet target | The planned target for Birmingham is not considered to be realistic in the timescale. | Preventing Unnecessary Admissions<br>The establishment of integrated multi-disciplinary teams based at the front door of hospitals, based upon the ADAPT model established at City Hospital.<br><br>Trusted Assessors<br>The roll out of a trusted assessor process in UHBFT following a successful pilot which saw a c35% reduction in delayed days for simple packages of care. The hospital OTs being granted trusted assessor status, following appropriate training, has freed up social care staff from assessments, hospital OTs can also directly input into the social care system, following appropriate data sharing agreements. This approach will be rolled out across HEFT and BCHCFT in the next quarter.<br><br>Review of CHC<br>The CCGs have commissioned and | As a system we are committed to achieving the required level of DToC, but this will require certainty in terms of resource allocation and a realistic timeframe to put in place longer-term sustainable solutions. |

** Your assessment of progress against the Delayed Transfer of Care target should reflect progress against the monthly trajectory submitted separately on the DToC trajectory template*

# Better Care Fund Template Q2 2017/18

**4. High Impact Change Model**

Selected Health and Well Being Board: Birmingham

| | | Maturity assessment | | | Narrative | | | |
|---|---|---|---|---|---|---|---|---|
| | | Q2 17/18 (Current) | Q3 17/18 (Planned) | Q4 17/18 (Planned) | 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** | Not yet established | Plans in place | | | This is a system challenge that has been r | First Newton Review report on 14/11. Main areas of work. Developing an integrated service supporting ED and short stay units to reduce LOS. Data sharing agreement with integrated IT systems. Capacity and flow tool at Solihull site. Improved commissioning information. Digital systems to better track performance. Work to be progressed once priorities agreed | Support required to implement will be determined during next phase of system diagnostic work. |
| Chg 2 | **Systems to monitor patient flow** | Plans in place | Plans in place | | | Partners have commissioned 'Newton' to undertake a system wide analysis, whilst immediate action is being taken to reduce DTOC for winter 2017/2018, system leaders recognise that it is essential to identify why Birmingham DTOC is so high.<br>-Teams are working together to review the assessment and commissioning processes for people ready for discharge from hospital. This has enabled the teams to identify where activity can be changed / stopped in order to speed up the process. | The Newton findings concerning in hospital flow and proposed actions will be considered following the presentation on 14/11 and integrated into current delivery programmes. Work to be progressed once priorities agreed.<br>Reviewing the existing process to make it leaner E.g. reviewing the commissioning process has reduced the timescale to identify provision by two days per client. For home support providers it has been possible to introduce a 'work around' which has reduced the time for commissioning the service by half a day.It is anticipated that the outline of a model could be in place by end Nov 2017. | Support required to implement will be determined during next phase of system diagnostic work. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Chg 3 | **Multi-disciplinary/multi-agency discharge teams** | Established | Established | | | Mult-displinary/multi-agency discharge teams are in place at all acute hospitals. Teams conduct daily joint ward visits to assess status and to plan for discharge. It is acknowledged that processes need to be refined through the system diagnostic work to improve co-ordination of activity. | First Newton Review report due on 14/11. Main areas of work, developing MDT teams supporting ED and short stay units. Joint BCC/CCG commissioning strategy for home care and resi/nursing home providers. Work to be progressed once priorities agreed. | Support required to implement will be determined during next phase of system diagnostic work. |
| Chg 4 | **Home first/discharge to assess** | Not yet established | Plans in place | | | The previous model of bed capacity out of hospital where people are further assessed is being reviewed and the preference is to get people home where possible | The Newton Recovery, Rehabilitation and Re-ablement review funded by the iBCF will report to system executives on 14/11. Initial feedback is that Birmingham does not have a home first model and this will be addressed. The Newton work includes indicative changes to capacity required and the financial consequences of changes for partners and options for change. The Support U Home programme in Solihull has already established this. Work to be progressed once priorities agreed | Support required to implement will be determined during next phase of system diagnostic work. |
| Chg 5 | **Seven-day service** | Plans in place | Established | | | Discussions taking place to establish the requirements for support services in order to ensure a fully functioning 7 day service offer. Review the need for support services to be available over a 7 day period | Recruitment of 10 Social Workers across the Acute Hospitals as the first phase in implementing a sustainable 7 day social work service is underway. | Support required to implement will be determined during next phase of system diagnostic work. |
| Chg 6 | **Trusted assessors** | Plans in place | Established | | | Scoping the trusted assessor model for care homes as part of the care home programme.<br>Front door team and trusted assessments between professionals being tested | Continuation of SIDs model at HEFT over winter. Incorporate short stay and base ward projects. OT Trusted assessor model has been rolled out across wards following successful evaluation in one trust. This has included data sharing agreements. Aim to roll out similar approach through OTs in HEFT and BCHCFT. | Support required to implement will be determined during next phase of system diagnostic work. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Chg 7 | **Focus on choice** | Plans in place | Established | | | Further review of the single system choice policy has been undertaken with actions identified to clarify the position of self funders. | The Newton Review, reporting on 14/11 will identify any opportunities/actions required to enhance the care home market which will enhance choice, including working collaboratively with the market to incentivise. | Support required to implement will be determined during next phase of system diagnostic work. |
| Chg 8 | **Enhancing health in care homes** | Plans in place | Established | | | Whilst Birmingham partners have commissioned additional capacity in short and long term beds to reduce delays in discharges from hospital, the benefit of such increases has not been always evident as the system has also been losing beds due to poor quality at the same time.<br><br>To establish a joint working group is in the process of being established to fully understand the needs of the care homes sector and options for MDT support | By working in partnership with CQC, commissioners has identified older adult bed based providers in Birmingham who are at risk of failure if their services do not improve. It has been agreed to fund additional commissioning staff capacity through iBCF to work with providers at risk of failure to support them to improve their quality and reduce the risk of CQC taking action around their failure to improve.<br>Health has been asked to bring forward the JQAF quality visits to these providers, (as health lead the quality work with Nursing Homes in the City). BCC will double up with health on the nursing home quality visits. | Support required to implement will be determined during next phase of system diagnostic work. |

| **Hospital Transfer Protocol (or the Red Bag Scheme)**<br>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. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | **Q2 17/18 (Current)** | **Q3 17/18 (Planned)** | **Q4 17/18 (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 | Plans in place | | There are no alternative plans in place | This work stream is part of the STP programme which is now being picked up by the system | Opportunities for integrated commissioning with BCC are now being investigated with joint projects particularly around support for care homes being developed.<br><br>Discussed as an action to be picked up | No support required currently |

# Better Care Fund Template Q2 2017/18

**5. Narrative**

Selected Health and Wellbeing Board: Birmingham

| Remaining Characters: | 15,085 |
|---|---|

**Progress against local plan for integration of health and social care**

There have been a number of key areas of progress in the last quarter:
1. A single interim accountable officer for the two largest CCGs in Birmingham (also including Solihull) was appointed in July, with the CCGs proposed merger being authorised in November. Formal arrangements around joint working are also being agreed with Sandwell and West Birmingham CCG. This has moved a reality of a single voice for health commissioning much closer and opportunities for integrated commissioning with BCC are now being investigated with joint projects particularly around support for care homes being developed.
2. An initial meeting of the 'Integrated care and support for those who wish to remain independent' STP programme chaired by the Director of Health and Social Care in BCC. This is a multi-agency group that will drive the identification of 'place' in Birmingham and how multi-disciplinary working will be established within these localities. An initial workshop is planned in December from which a more detailed programme will be developed. The agreement of localities will be a key milestone within the city as it has not been possible to reach agreement to date.
3. The 'integrated care and support when people need urgent and emergency care' programme has agreed a joint winter plan which incorporates many of the elements of iBCF and delivery is progressing. These plans as well as supporting winter also aim as far as possible to support a future integrated system. Of specific note are: a. The establishment of integrated multi-disciplinary teams based at the front door of hospitals, based upon the ADAPT model established at City Hospital which has considerably lower DTOcs than other hospitals in Birmingham (see below); b. The roll out of a trusted assessor process in UHBFT following a successful pilot which saw a c35% reduction in delayed days for simple packages of care. The hospital OTs being granted trusted assessor status, following appropriate training, has freed up social care staff from assessments, hospital OTs can also directly input into the social care system, following appropriate data sharing agreements. This approach will be rolled out across HEFT and BCHCFT in the next quarter. c. The CCGs have commisisoned and received an independent review of CHC processes to improve the DTOC position in this area of health delays. A senior executive has been identified to oversee the improvement plan which is being developed and individuals released from current roles to prioritise.
d. The system wide Choice Policy is further clarifying the position in relation to self funders to assist staff. 4. The completion of the assessment phase of the independent review of the Recovery, Rehabilitation and Re-ablement system in the city by Newton Europe. Newton reported their findings on 14th November to executives across the system. These findings will form the basis of a formal agreement around multi-agency collaboration to achieve integration within the city and a communications strategy for staff and the public, alongside the STP production 'Phyllis' which is a theatre performance telling the story of Phyllis and the negative consequences of poor integration to her and her family. 5. 'Phyllis' was developed from a series of interviews with health and social care staff and people who have received services and their families. It has initally been performed at STP Board and hospital

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: | 18,961 |
|---|---|

**Integration success story highlight over the past quarter**

Following Audits at the front door at the acute trusts over the summer, a model for MDT at the front door has been developed and has been implemented at HEFT since October 2017. The model is geriatrician led with an integrated community, therapy, and social services team. The team predominantly see patients from the assessment unit and will look for alternative provision in the community for care if this is more appropriate, instead of the patient being referred to a base ward. The MDT have been working together and understanding each other job roles before modifying to develop this model of working. As a consequence there is scope to develop the trusted assessment model. The impact of having the MDT at the front door has led to better communication, more coordination and combined decision making. Currently the model is focused on assessment but as more provision is identified in the community and other services are developed there will be more opportunity to get people to the most appropriate destination of care.

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 Q2 2017/18

**Checklist**

**<< Link to Guidance tab**

**Incomplete Template**

**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 | No |

| | |
|---|---|
| Sheet Complete: | No |

**2. National Conditions & s75**

| | 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? If no please 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 | D7 | Yes |
| Res Admissions Target performance | D8 | Yes |
| Reablement Target performance | D9 | Yes |
| DToC Target performance | D10 | Yes |
| NEA Challenges | E7 | Yes |
| Res Admissions Challenges | E8 | Yes |
| Reablement Challenges | E9 | Yes |
| DToC Challenges | E10 | Yes |
| NEA Achievements | F7 | Yes |
| Res Admissions Achievements | F8 | Yes |
| Reablement Achievements | F9 | Yes |
| DToC Achievements | F10 | Yes |
| NEA Support Needs | G7 | Yes |
| Res Admissions Support Needs | G8 | Yes |
| Reablement Support Needs | G9 | Yes |
| DToC Support Needs | G10 | Yes |

| | |
|---|---|
| Sheet Complete: | Yes |

**4. HICM**

| | Cell Reference | Checker |
|---|---|---|
| Early discharge planning Q2 | D8 | Yes |
| Systems to monitor patient flow Q2 | D9 | Yes |
| Multi-disciplinary/multi-agency discharge teams Q2 | D10 | Yes |
| Home first/discharge to assess Q2 | D11 | Yes |
| Seven-day service Q2 | D12 | Yes |
| Trusted assessors Q2 | D13 | Yes |
| Focus on choice Q2 | D14 | Yes |
| Enhancing health in care homes Q2 | D15 | Yes |
| Red Bag scheme Q2 | D19 | Yes |
| Early discharge planning, if Mature or Exemplary please explain | G8 | Yes |
| Systems to monitor patient flow, if Mature or Exemplary please explain | G9 | Yes |
| Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain | G10 | Yes |
| Home first/discharge to assess, if Mature or Exemplary please explain | G11 | Yes |
| Seven-day service, if Mature or Exemplary please explain | G12 | Yes |
| Trusted assessors, if Mature or Exemplary please explain | G13 | Yes |
| Focus on choice, if Mature or Exemplary please explain | G14 | Yes |
| Enhancing health in care homes, if Mature or Exemplary please explain | G15 | Yes |
| Red Bag scheme, if Mature or Exemplary please explain | G19 | Yes |
| Early discharge planning Challenges | H8 | Yes |
| Systems to monitor patient flow Challenges | H9 | Yes |
| Multi-disciplinary/multi-agency discharge teams Challenges | H10 | Yes |
| Home first/discharge to assess Challenges | H11 | Yes |
| Seven-day service Challenges | H12 | Yes |
| Trusted assessors Challenges | H13 | Yes |
| Focus on choice Challenges | H14 | Yes |
| Enhancing health in care homes Challenges | H15 | Yes |
| Red Bag Scheme Challenges | H19 | Yes |
| Early discharge planning Additional achievements | I8 | Yes |
| Systems to monitor patient flow Additional achievements | I9 | Yes |
| Multi-disciplinary/multi-agency discharge teams Additional achievements | I10 | Yes |
| Home first/discharge to assess Additional achievements | I11 | Yes |
| Seven-day service Additional achievements | I12 | Yes |
| Trusted assessors Additional achievements | I13 | Yes |
| Focus on choice Additional achievements | I14 | Yes |
| Enhancing health in care homes Additional achievements | I15 | Yes |
| Red Bag Scheme Additional achievements | I19 | Yes |
| Early discharge planning Support needs | J8 | Yes |
| Systems to monitor patient flow Support needs | J9 | Yes |
| Multi-disciplinary/multi-agency discharge teams Support needs | J10 | Yes |
| Home first/discharge to assess Support needs | J11 | Yes |
| Seven-day service Support needs | J12 | Yes |
| Trusted assessors Support needs | J13 | Yes |
| Focus on choice Support needs | J14 | Yes |
| Enhancing health in care homes Support needs | J15 | Yes |
| Red Bag Scheme Support needs | J19 | 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 |