APPENDIX 1

Better Care Fund Template Q2 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Isle of Wight

		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**	Plans in place	Plans in place	Established		Implementation of consistent approach to robust processes to ensure all patients have agreed EDD at point of admission.	Admission pack with EDD agreed implementation commenced across all Business Units. Roll out of SAFER and Red to Green days continues.	Communications and stakeholder support. Continued support through ECIP team.
Chg 2	**Systems to monitor patient flow**	Plans in place	Established	Established		Implementation of IT System (Medworxx) to support patient flow has been delayed by 3 months with completion now due by March 2018 Alternative work arounds using existing IT systems are being discussed as an	Multi-agency patient Navigation team now working 7 days a week Review of team roles and responsibilities in place to ensure optimisation of skills to support early discharge planning and facilitation.	Capacity to support Trust IT team to implement Medworxx
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Established	Established		Lack of clarity around setting EDD across all disciplines on admission. Some inconsistencies around MDT approach.	All patients with a LOS =>7 days discussed at MDT. Overall LOS on average reduced by 3 days since review commenced. Daily Board rounds commenced and	Continued support from ECIP
Chg 4	**Home first/discharge to assess**	Plans in place	Established	Established		Lack of clarity across the system in regard	D2A Model commenced beginning of September. Focus on frailty, identification by Nurse Specialist at front, screening tool in place. Where possible patients are being sent home for full screening in the	Training around D2A across the system.
Chg 5	**Seven-day service**	Plans in place	Plans in place	Established		Implementation of consistent approach to robust processes to ensure all patients have agreed EDD at point of admission. Implementation of IT bed management	Admission pack with EDD as integral and mandatory agreed. Training and implementation commenced across all Business Units. Roll out of SAFER and Red to Green days	Continued support from ECIP Capacity to support Trust IT team to implement Medworxx.
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Established		Building trust across care home sector has	commenced in partnership with Care Home sector. Initial discussions re implementation and training in place. Agreed to commence with those patients returning to placement.	None identified at this stage
Chg 7	**Focus on choice**	Plans in place	Established	Established		Potential for some inconsistencies across the acute system in regard to issuing choice letter.	Commenced Patient Activation including promoting self-care, supporting carers (linking with island wide Carer project), communication and information at admission	Training support staff with decisions and issuing of 'Choice' letter.
Chg 8	**Enhancing health in care homes**	Plans in place	Established	Established		None identified at this stage	Representation from care home sector on H2H group. Trusted Assessors project scoped; implementation to commence from January 2017.	None identified at this stage

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.									
		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**	Plans in place	Plans in place	Established		None identified at this stage	Implementation on track. 10 Nursing Homes and 7 residential homes on board as part of first wave of implementation. Work plan in place, go live date 1st January 2017.	None identified at this stage

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.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 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 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 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 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

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:	Isle of Wight
Completed by:	Catherine Budden
E-mail:	catherine.budden@iow.nhs.uk
Contact number:	01983 552346
Who signed off the report on behalf of the Health and Wellbeing Board:	Dr Michelle Legg, Chair, IOW CCG and Cllr Clare Mosdell, Cabinet

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

Better Care Fund Template Q2 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Isle of Wight

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: Isle of Wight

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	Performance has seen increased activity overall against plan which was a stretch target based on assumed delivery of QIPP schemes which have not yet fully delivered.	Whilst activity has not reduced over	Not at this stage. There are number of transformation programmes in place that to contribute to reduced non elective admissions.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	High levels of existing dependency c	Consistent and stringent manageme	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	On track to meet target	Double handed calls in remote areas. Ensuring reablement offered to the right cohort who will benefit from the service and increase in take up. Decrease in quarter expected to be	Increased investment in teams to su	n/a
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	On track to meet target	Managing anticipated spikes in delays as further pathway improvements are rolled out. MEDWORXX bed management system implementation has been delayed in the Trust	National DTOC Target for September was exceeded and we remain on track to continue achieving. SHREWD is in place and work is ongoing to go live with system data	ECIP continue to provide support to the system. Clear identification of DTOCs where pathways of care involve multiple provieder, e.g. in Southampton and Portsmouth

** 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

5. Narrative

Selected Health and Wellbeing Board: Isle of Wight

Remaining Characters:	14,472

Progress against local plan for integration of health and social care

The Local Care Board has continued bed down during Q2, with robust programme governance overseeing the implementation and delivery of the eight priority programmes.
There is agreement from Local Care Board to move towards Outcomes Based Commissioning from 2018/19. This follows a review of community based services and will focus initially on supporting the implementation of Integrated Locality Services and the Urgent Care Blueprint.
Options for integrating commissioning functions have been developed during the quarter and, once approve by Local Care Board, formal HR consultation and service planning can begin.

Updates for Individual BCF Schemes:
• Locality Community Model
Stakeholder event for West & Central Locality reached consensus on a 'hub and spoke' model across Newport, Cowes and Freshwater. Training and development session for ILS continue. Work is beginning on the alliance contract and financial modelling.

• Hospital to Home
Roll out of Red to Green and Safer bundle is going well, aiming to complete by end November and work has been undertaken on other national initiatives including (EndPJParalysis', 'Fit2Sit' and Last 1000 Days Daily multi-professional review of each patient with 7 day length of stay or

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:	17,894

Integration success story highlight over the past quarter

HOSPITAL TO HOME

Progress within the quarter
Roll out of SAFER bundle and Red2Green has continued through Q2- building on from the initial focussed effort in the two main medical wards (Pareto principal)
Work on other national initiatives and 8HIC have been undertaken including #EndPJParalysis, Fit2Sit and Last 1000 Days; this has been of some success both internally and externally with local media support. Auditing being compiled regarding the impact of these campaigns to establish next steps in furthering their agendas.
Successful business case for patient flow/bed management software ('Medworxx') has been completed with implementation plan commencing in Q3 ahead of winter.
Daily multi-professional review of each patient with 7 day length of stay or more

Depth
The programme is active internally across the whole trust as well as into community settings.
There is more effective partnership working with Adult Social Care Teams, partners in the voluntary sector and improving engagement with the

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]

Complete 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	Yes

Sheet Complete:	Yes

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

IOW BCF Q2 2017-18 Report

CONFIRMATION OF NATIONAL CONDITIONS

National Condition	Confirmation
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
Have the funds been pooled via a s.75 pooled budget?	Yes

METRICS

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	Performance has seen increased activity overall against plan which was a stretch target based on assumed delivery of QIPP schemes which have not yet fully delivered.	Whilst activity has not reduced overall the spend has reduced significantly due to case mix driven by reductions in general medicine, stroke and paediatrics.	Not at this stage. There are number of transformation programmes in place that to contribute to reduced non elective admissions.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	High levels of existing dependency on residential and nursing placements. Ability to access alternative sources of care and support are reliant on new provision and commissioning timescales.	Consistent and stringent management of the placements remains a priority for this performance to be maintained.	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	On track to meet target	Double handed calls in remote areas. Ensuring reablement offered to the right cohort who will benefit from the service and increase in take up. Decrease in quarter expected to be back up to the usual high performance in the next quarter.	Increased investment in teams to support this service area and the range of professional support within the teams to maximise the effectiveness.	n/a
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	On track to meet target	Manage anticipated spikes in delays as further pathway improvements are rolled out. MEDWORXX bed management system implementation has been delayed in the Trust, so will not now be fully implemented until March 2018. This may impact on progress to our pathway and flow improvments within the Trust, thus impacting Hospital to Home workstream.	National DTOC Target for September was exceeded and we remain on track to continue achieving. SHREWD is in place and work is ongoing to go live with system data ahead of winter.	ECIP continue to provide support to the system. Clear identification of DTOCs where pathways of care involve multiple provider, e.g. in Southampton and Portsmouth

		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**	Plans in place	Plans in place	Established		Implementation of consistent approach to robust processes to ensure all patients have agreed EDD at point of admission.	Admission pack with EDD agreed implementation commenced across all Business Units. Roll out of SAFER and Red to Green days continues. Red to Green now to be extended to Community Rehabilitation bed base. Mapping of all discharge pathways underway. CHC, stroke and frailty complete. Rehabilitation and reablement pathways under completion. Work with communications. (impact on HIC 2)	Communications and stakeholder support. Continued support through ECIP team.
Chg 2	**Systems to monitor patient flow**	Plans in place	Established	Established		Implementation of IT System (Medworxx) to support patient flow has been delayed by 3 months with completion now due by March 2018 Alternative work arounds using existing IT systems are being discussed as an interim measure for the winter period Q3.	Multi-agency patient Navigation team now working 7 days a week Review of team roles and responsibilities in place to ensure optimisation of skills to support early discharge planning and facilitation. (impact on HIC 1)	Capacity to support Trust IT team to implement Medworxx

		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 3	**Multi-disciplinary /multi-agency discharge teams**	Plans in place	Established	Established		Lack of clarity around setting EDD across all disciplines on admission. Some inconsistencies around MDT approach.	All patients with a LOS =>7 days discussed at MDT. Overall LOS on average reduced by 3 days since review commenced. Daily Board rounds commenced and being rolled out across wards as part of SAFER implementation. Twice weekly hard to place patient meetings continue.	Continued support from ECIP
Chg 4	**Home first/discharge to assess**	Plans in place	Established	Established		Lack of clarity across the system in regard to D2A approach.	D2A Model commenced beginning of September. Focus on frailty, identification by Nurse Specialist at front, screening tool in place. Where possible patients are being sent home for full screening in the community. Where admission required, initial evidence suggests LOS reduced.	Training around D2A across the system.
Chg 5	**Seven-day service**	Plans in place	Plans in place	Established		Implementation of consistent approach to robust processes to ensure all patients have agreed EDD at point of admission. Implementation of IT bed management system (Medworxx) stalled.	Admission pack with EDD as integral and mandatory agreed. Training and implementation commenced across all Business Units. Roll out of SAFER and Red to Green days continues. Red to Green and now to be extended to Community Rehabilitation bed base. (impact on HIC 1)	Continued support from ECIP Capacity to support Trust IT team to implement Medworxx.

		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 6	**Trusted assessors**	Plans in place	Plans in place	Established		Building trust across care home sector has proved challenging.	Trusted Assessor model commenced in partnership with Care Home sector. Initial discussions re implementation and training in place. Agreed to commence with those patients returning to placement.	
Chg 7	**Focus on choice**	Plans in place	Established	Established		Potential for some inconsistencies across the acute system in regard to issuing choice letter.	Commenced Patient Activation including promoting self-care, supporting carers (linking with island wide Carer project), communication and information at admission. System wide initiatives, including PJ Paralysis and 1000 days in place. PDSA approach used against all initiatives. Hard to place patient meetings to identify where 'Choice' letter to be used . Executive level weekly DTOC meetings. Implementation of bed management system to identify more complex patients earlier in their journey Use of SPOC (single point of commissioning) for all people requiring further support (includes self-funders at no charge)	Training so support staff with decisions and issuing of 'Choice' letter.

		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 8	**Enhancing health in care homes**	Plans in place	Established	Established			Red bag scheme going forward. Representation from care home sector on H2H group. Trusted Assessors project scoped; implementation to commence from January 2017.	

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.

		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**	Plans in place	Plans in place	Established			Implementation on track. 10 Nursing Homes and 7 residential homes on board as part of first wave of implementation. Work plan in place, go live date 1st January 2017.	

PROGRESS AGAINST LOCAL PLAN

The Local Care Board has continued bed down during Q2, with robust programme governance overseeing the implementation and delivery of the eight priority programmes.

There is agreement from Local Care Board to move towards Outcomes Based Commissioning from 2018/19. This follows a review of community based services and will focus initially on supporting the implementation of Integrated Locality Services and the Urgent Care Blueprint.

Options for integrating commissioning functions have been developed during the quarter and, once approve by Local Care Board, formal HR consultation and service planning can begin.

Updates for Individual BCF Schemes:

- **Locality Community Model**

Stakeholder event for West & Central Locality reached consensus on a 'hub and spoke' model across Newport, Cowes and Freshwater. Training and development session for ILS continue. Work is beginning on the alliance contract and financial modelling.

- **Hospital to Home**

Roll out of Red to Green and Safer bundle is going well, aiming to complete by end November and work has been undertaken on other national initiatives including 'EndPJParalysis', 'Fit2Sit' and Last 1000 Days.Daily multi-professional review of each patient with 7 day length of stay or more are in place; Medworxx bed management system has been procured.
The iBCF has been used in the creation of two specialist reablement home care teams that provide an Island-wide service specialising in complex two carer homecare provision - which has historically contributed to increase length of stay in the acute setting or defaulted into residential and nursing placements
The service is professionally led by occupational therapists and physiotherapists, these two teams provide up to six weeks free home care reablement intervention to people coming out of hospital.
Challenges: Further work to be undertaken in streamlining and reviewing care pathways and joint processes between health and social care; delays in recruiting project support team members; managing the expected spike in delays as further pathway improvements are rolled out across wards, e.g. as 'red to green' are implemented. Deployment of the MEDWORXX bed management system has been delayed within the Trust, so will not now be fully implemented until March 2018. This may impact on progress to our pathway and flow improvements within the Trust, thus impacting Hospital to Home workstream. Short term work arounds are being developed using exiting IT platforms.

- **Carers**

The second draft of the Carers Strategy has now been completed following close work with Carers IW and People Matter IW. Increase of 44 people registered with Carers since the start of 2017/18.
Challenges: The Carers Strategy sign off is more than 30 days behind schedule. There has been a delay in the allocation of carers lead within each ASC team, now expected to be completed in December 2017.

- **Living Well**

Key roles have been recruited to, staff are in post and the 'soft' launch has taken place. The service will be ready to accept referrals from 1st November 2017, with the full launch will take place on 15th November 2017. Grant funding agreement is in place and funds transferred.

- **ASC Care Close to Home**

A Dynamic Purchasing System for LD Care Homes, Day Opportunities and Supported Living has been successfully established. Personal Assistant Hub went out to tender on Monday 18th September 2017.

- **Support for Providers**

Independent Sector Secondment Commissioning Lead has been recruited; Sector led training is in development with first cohort of training programme for registered Managers starting in December 2017.
Challenges: While sector led training is in development, completion may be delayed as providers are engaged in developing the format and content of training.

- **Promoting Independence**

Additional funding has been transferred to Wightcare for the purchase of the additional equipment including 75 Own phones to support "simple" discharges from hospital. Other orders have been placed. Short term Wheelchair Service Contract is in place.
Risk: delivery of telehealth to outreach team due to lack of engagement with lack of consensus on direction of travel at an operational level.

- **Rehabilitation, Reablement and Recovery**

Specification for Community based RRR beds has been agreed and procurement is underway.
Challenges: transformation of in-hospital to community teams to support the RRR beds; due to procurement delays there will be slippage on mobilisation of community beds.

- **Mental Health**

The Blueprint for the future of Mental Health services on the Island is in development. Proposal paper for day services is underway. The Out of Area Placement reviews are underway and the Business Case for inpatient services is due for completion in early November.
Challenges: Not all the programme support staff are in place yet which has led to delays in milestone delivery. Business cases are behind schedule but remain on track for delivery.

- **LD Transformation**

LD Strategy in development and on target. Peer Review Team progress visit on 23 October confirmed progress against all of its 16 recommendations. First new development for supported living complete; £1.9m capital funding successfully bid from NHS England which will enable the purchase of 12 supported living flats; Contract exchanged on Carisbrooke house - 8 units of accommodation to be delivered April 2018.

- **Employment Support**

Review of current employment provision completed. Co-production of proposal paper on target.

INTEGRATION SUCCESS STORY

HOSPITAL TO HOME

Progress within the quarter

- Roll out of SAFER bundle and Red2Green has continued through Q2- building on from the initial focussed effort in the two main medical wards (Pareto principal)
- Work on other national initiatives and 8HIC have been undertaken including #EndPJParalysis, Fit2Sit and Last 1000 Days; this has been of some success both internally and externally with local media support. Auditing being compiled regarding the impact of these campaigns to establish next steps in furthering their agendas.
- Successful business case for patient flow/bed management software ('Medworxx') has been completed with implementation plan commencing in Q3.
- Daily multi-professional review of each patient with 7 day length of stay or more

Depth

- The programme is active internally across the whole trust as well as into community settings.
- There is more effective partnership working with Adult Social Care Teams, partners in the voluntary sector and improving engagement with the Independent sector.
- The programme has activities across all high impact change areas

Scale

- Programme roll-out of Safer and Red2Green is on schedule to be completed throughout all hospital wards by November 2017.

Sustainability

- The multi-agency approach is patient centred – act as advocates for the patient- Doing the right things every time- embedding national best practice
- The Leadership changes across the Trust, Adult Social Care and other system partners are promoting and embodying a supportive learning approach
- Making significant cultural and practice changes stick takes time- starting small has drawn interest from other wards and depts that then become keen to adopt the models– it becomes a social movement, with champions and visible results

Impact

- The programme has eliminated long waits for a bed in ED and exit block – concentrating in 4 hours, not 12 hours
- ED performance now averaging 91% Jul/Aug/Sept
- Bed occupancy has been brought under 92% consistently over Q2
- By Sept LoS had been reduced by 3 days
- DTOC- The System achieved its overall DTOC target in September.

QUARTERLY REPORTING FROM LOCAL AUTHORITIES TO DCLG IN RELATION TO THE IMPROVED BETTER CARE FUND

IMPORTANT: Please DO NOT alter the format of this spreadsheet by inserting, deleting or merging any cells, rows or columns. The data from this spreadsheet are transferred directly into a DCLG database using a macro and your return may flag as an error if you attempt to alter the format. You can, however, resize the height and width of rows and columns if you need more space.

Instructions:
1. Select your local authority from the drop-down menu in Cell C11.
2. Enter the password provided in your email from DCLG into Cell C13
2. Complete Sections A to D below by filling in the pink boxes as instructed. If copying and pasting in content from another document please paste your text directly into the formula bar.
3. Save the completed form in the original MS Excel macro-enabled workbook format. Do not convert this spreadsheet to another file format or provide any information in additional attachments.
4. Once completed and saved, please e-mail this MS Excel file by 20 October 2017 to: CareandReform2@communities.gsi.gov.uk

Local authority: (Select from drop-down menu)	**Isle of Wight UA**
Enter password (as provided in email from DCLG)	**USUW97**
E-code	**E2101**
Period	**Quarter 2 (July 2017 – September 2017)**

Section A

A1. Provide a narrative summary for Quarter 2 which follows up the information you provided in Section A at Quarter 1. What are the key successes experienced? What are the challenges encountered?

The Improved Better Care Fund (IBCF) monies have been used in accordance with the grant conditions and in order to transform outcomes for those we serve. There has been unanimity across ASC and health as to their distribution. We have invested IBCF funds in a hospital admission avoidance scheme and exceeded our nationally established September targets for delayed transfers of care. Indeed, our local DTOC performance will be the subject of a national hospital to home best practice visit in November. Our local DTOC improvement journey has straddled commissioning processes and provider capacity, operational delivery systems and systems wide governance. Weekly DTOC meetings chaired by the DASS and attended by senior officers from Adult Social Care, the Trust and the CCG have ensured: that DTOC is accorded the highest level of system wide focus and attention; to maintain good performance; and support the system development of local winter plans. DTOC performance for the week ending 6 October 2017 was: adult social care - 1.0 per 100,000 population (target is 4.58); health – 1.9 per 100,000 (target is 2.29); combined – 2.9 per 100,000 (target is 6.87). IBCF funds have also been used to support the delivery of Care Close to Home – the new strategy for adult social on the island - as well as the priorities set out in the Local Care Plan. For instance, £521k of ibcf funds are invested in the delivery of specialist reablement home care – which will further support reductions in DTOCSs as, in doing so, mitigate any perverse outcome that low DTOC rates are accompanied by high rates of admissions into residential and nursing care homes straight from hospital. We have also invested a further £500k IBCF funds in the delivery of our Technology Enhanced Care strategy. Finally by way of overview here, we have commissioned the voluntary and community sector to deliver a new Living Well service – which will help avoid hospital admissions, facilitate prompt discharge and provide assured practical support services to people whose assessed needs fall below adult social care thresholds (£600k). We have also worked with local providers to develop a free single training and CPD offer available to all registered adult social care providers on island, which will support quality improvement across the care sector.

A2. Provide progress updates on the individual initiatives/projects you identified in Section A3 at Quarter 1. You can provide information on any additional initiatives/projects not cited at Quarter 1 to the right of the boxes below.

	Initiative/Project 1	Initiative/Project 2	Initiative/Project 3	Initiative/Project 4	Initiative/Project 5
A2a. Individual title for each initiative/project (Automatically populated based on information provided in Quarter 1. Please ensure your password is entered correctly in cell C13).	Work Stream Leads complete for each of their work streams Assistive Technology	Support for Providers	Reablement	DTOC	Living Well - an early help offer
A2b. Use the drop-down options provided to report on progress since Quarter 1.	2. In progress: no results yet	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	2. In progress: no results yet

A2c. You can add some brief commentary on the progress to date if you think this will be helpful (in general no more than 2 to 3 lines).	Specialist equipment is being purchased and qoutes are being obtained form suppliers for delivery.	Seconded commissioning lead has been recruited, training offers commissioned, delivery commences Dec 17/Jan 2018	2 specialist reablement Care teams recruited to date; supported with hospital discharges and some crisis in the community to prevent admissions to hospital and residential/nursing placements. Currently recruiting further care support teams & Therapy specialists to build the required capacity to meet demand ongoing.	Close joint working across organisations to deliver better results for those we serve, have resulted in targets being met as per trajectory. ASC DTOC ave dailt=y rate: Sept Target = 4.58. Actual at 011017 = 3.1	Staff have been receruited for key roles within the programme. The launch event is on 5th October 2017

Section B

Report the actual impact of the additional funding on:

	a) The total number of home care packages provided for the whole of 2017/18:	**b) The total number of hours of home care provided for the whole of 2017/18:**	**c) The total number of care home placements for the whole of 2017/18:**
B1. Provide figures to illustrate your plans for the whole of 2017/18 prior to the announcement of the additional funding for adult social care at Spring Budget 2017. PLEASE USE WHOLE NUMBERS ONLY WITH NO TEXT. Use question B4 below if you wish to provide any text/commentary.	704	337,073	360
B2. Provide figures to illustrate your current plans for the whole of 2017/18 (i.e. after the announcement of the additional funding for adult social care at Spring Budget 2017). PLEASE USE WHOLE NUMBERS ONLY WITH NO TEXT. Use question B4 below if you wish to provide any text/commentary.	636	274,790	298
B3. Difference between pre- and post-Spring Budget announcement plans: B2 - B1 (automatically calculated).	-68	-62,283	-62
B4. You can add some brief commentary on the figures provided above if you wish.	Fiigures above relate to actual packages deliverd not planned packages. No. of home care packages (people) is the numbers receiving home care during the first 6 months of 17/18 only. This figure will increase as the year progresses.	Figures above relate to actual hours of care delivered and receipted (not planned hours). B2: The predicted number of hours is based upon the number of receipted hours for 17/18 YTD multiplied by 2. This shows a large drop in the number hours provided but analysis indicates a rise of aprox. 20% in the number of new cases in the 1st 6 months of 17/18 compared to 16/17. This would suggest people that start new packages are receiving them for a shorter period of time due to the success of reablement and prevention work.	ONS population

Section C

Metric 1	**Metric 2**	**Metric 3**	**Metric 4**	**Metric 5**

C1a. List up to 10 additional metrics you are measuring yourself against, as mentioned in Section C of the Q1 returns.	• Reduction in % of initial contact referrals to ASC that result in new permanent admissions to residential or nursing care: Target = 5%	• An increase in the percentage of contracted registered providers that achieve good or outstanding in the CQC Inspection outcomes: Target = to reach the national average as per October 16 as a minimal	• Reducing average bed occupancy: Target = 92%	• Increase in those discharged via rehabilitation & reablement (ASCOF 2b Part 1): Target = 91%	• Increase in the number of carers assessments undertaken in the year: Target = 10% increase = 31%