Better Care Fund Template Q3 2019/20

1. Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements document for 2019-20 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

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 the
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

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

BCF quarterly reports 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

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

Quarterly reporting for the 'improved Better Care Fund' (iBCF grant) will be required in Q4 19/20 and is not required for the current quarter Q3 19/20.

The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

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

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

Checklist (2. Cover)

1. This section 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
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

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will
6. Please ensure that all boxes on the checklist tab are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, cont
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
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete

3. National Conditions

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 2019/20 (link below) continue to be met
https://www.gov.uk/government/publications/better-care-fund-planning-requirements-for-2019-to-2020

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

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG
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

4. Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and achievements realised.

As a reminder, if the BCF plans should be referenced as below:
- Residential Admissions and Reablement: BCF metric plans were set out and collected via the BCF Planning
- Non Elective Admissions (NEA): The BCF metric plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions at a HWB footprint. These plans were made available to the local areas via the respective Better Care Managers and remain valid. In case a reminder of your BCF NEA plan at HWB level is helpful, please write into your Better Care Manager in the first instance or the inbox england.bettercaresupport@nhs.net
- Delayed Transfers of Care (DToC): The BCF metric ambitions for DToC are nationally set and remain the same as the previous year (2018/19) for 2019/20. The previous year's plans on the link below contain the
https://www.england.nhs.uk/publication/better-care-fund-2018-19-planning-data/

This sheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, 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
- In providing the narrative on Challenges and Support needs, and Achievements, 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 useful information. Please also reflect on the metric performance trend when compared to the quarter from

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

5. HICM

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, for the reported quarter, and anticipated trajectory for the future quarter, of each of the eight HICM changes and the red-bag scheme along with the corresponding implementation challenges,

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
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
Established - The initiative has been established within the HWB area but has not yet provided proven
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-
For the purposes of the BCF in 2019/20, local areas set out their plans against the model applicable since 2017/18. Please continue to make assessments against this erstwhile HICM model and any refreshed

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

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

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

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

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

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 it has been agreed to collect information on its implementation locally via The BCF quarterly reporting template as a single point of collection.
- 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: The quick guide is available on the link https://www.england.nhs.uk/publication/redbag/

Further guidance is also available on the Kahootz system or on request from the NHS England Hospital to england.ohuc@nhs.net

6. Integration Highlights

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

Where this success story relates to a particular scheme type (as utilised in BCF planning) please select the scheme type to indicate that or the main scheme type where the narrative relates to multiple

Where the narrative on the integration success story relates to progressing one of the Enablers for Integrated Care, please select the main Enabler from the drop down. SCIE Logic Model for Integrated Care: https://www.scie.org.uk/integrated-care/measuring-evaluating/logic-model

7. WP Grant

Reporting for Winter Pressures Grant is being collected alongside the BCF in a single mechanism. For this quarter, the reporting is primarily seeking narratives and confirmation on progress against the delivery of the plans set out for the Winter Pressures Grant as part of the BCF planning process.

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2. Cover

Version 1.1

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.

- As in previous quarters, the BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF Grant information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately.

- The Winter Pressures Grant is pooled within the BCF and is part of the BCF plans. Q3 and Q4 19/20 quarterly reporting for the BCF include a separate tab to report on the Winter Pressures Grant.

Health and Wellbeing Board:	Cumbria
Completed by:	Laura Barton / Colin Phipps
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Who signed off the report on behalf of the Health and Wellbeing Board:	Katherine Fairclough

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
2. Cover	0
3. National Condition & s75	0
4. Metrics	0
5. HICM	0
6. Integration Highlights	0
7. WP Grant	0

<< Link to Guidance tab

2. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C19	Yes
Completed by:	C21	Yes
E-mail:	C23	Yes
Contact number:	C25	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C27	Yes

Sheet Complete:	Yes

3. National Conditions

^^ Link Back to top

	Cell Reference	Checker
1) Plans to be jointly agreed?	C9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C10	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C11	Yes
4) Managing transfers of care?	C12	Yes
1) Plans to be jointly agreed? If no please detail	D9	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D10	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D11	Yes

4) Managing transfers of care? If no please detail	D12	Yes

Sheet Complete:	Yes

4. Metrics ^^ Link Back to top

	Cell Reference	Checker
Non-Elective Admissions performance target assesment	D12	Yes
Residential Admissions performance target assesment	D13	Yes
Reablement performance target assesment	D14	Yes
Delayed Transfers of Care performance target assesment	D15	Yes
Non-Elective Admissions challenges and support needs	E12	Yes
Residential Admissions challenges and support needs	E13	Yes
Reablement challenges and support needs	E14	Yes
Delayed Transfers of Care challenges and support needs	E15	Yes
Non-Elective Admissions achievements	F12	Yes
Residential Admissions achievements	F13	Yes
Reablement achievements	F14	Yes
Delayed Transfers of Care achievements	F15	Yes

Sheet Complete:	Yes

5. High Impact Change Model ^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning - Q3 19/20 (Current)	D15	Yes
Chg 2 - Systems to monitor patient flow - Q3 19/20 (Current)	D16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Q3 19/20 (Current)	D17	Yes
Chg 4 - Home first/discharge to assess - Q3 19/20 (Current)	D18	Yes
Chg 5 - Seven-day service - Q3 19/20 (Current)	D19	Yes
Chg 6 - Trusted assessors - Q3 19/20 (Current)	D20	Yes
Chg 7 - Focus on choice - Q3 19/20 (Current)	D21	Yes
Chg 8 - Enhancing health in care homes - Q3 19/20 (Current)	D22	Yes
Red Bag Scheme - Q3 19/20 (Current)	D27	Yes
Chg 1 - Early discharge planning - If Q3 19/20 mature or exemplary, Narrative	F15	Yes
Chg 2 - Systems to monitor patient flow - If Q3 19/20 mature or exemplary, Narrative	F16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - If Q3 19/20 mature or exemplary, Narrative	F17	Yes
Chg 4 - Home first/discharge to assess - If Q3 19/20 mature or exemplary, Narrative	F18	Yes
Chg 5 - Seven-day service - If Q3 19/20 mature or exemplary, Narrative	F19	Yes
Chg 6 - Trusted assessors - If Q3 19/20 mature or exemplary, Narrative	F20	Yes
Chg 7 - Focus on choice - If Q3 19/20 mature or exemplary, Narrative	F21	Yes
Chg 8 - Enhancing health in care homes - If Q3 19/20 mature or exemplary, Narrative	F22	Yes
Red Bag Scheme - If Q3 19/20 no plan in place, Narrative	F27	Yes
Chg 1 - Early discharge planning - Challenges and Support needs	G15	Yes
Chg 2 - Systems to monitor patient flow - Challenges and Support needs	G16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Challenges and Support needs	G17	Yes
Chg 4 - Home first/discharge to assess - Challenges and Support needs	G17	Yes
Chg 5 - Seven-day service - Challenges and Support needs	G18	Yes
Chg 6 - Trusted assessors - Challenges and Support needs	G19	Yes
Chg 7 - Focus on choice - Challenges and Support needs	G20	Yes
Chg 8 - Enhancing health in care homes - Challenges and Support needs	G21	Yes
Red Bag Scheme - Challenges and Support needs	G27	Yes
Chg 1 - Early discharge planning - Milestones / impact	H15	Yes
Chg 2 - Systems to monitor patient flow - Milestones / impact	H16	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams - Milestones / impact	H17	Yes
Chg 4 - Home first/discharge to assess - Milestones / impact	H18	Yes
Chg 5 - Seven-day service - Milestones / impact	H19	Yes
Chg 6 - Trusted assessors - Milestones / impact	H20	Yes
Chg 7 - Focus on choice - Milestones / impact	H21	Yes
Chg 8 - Enhancing health in care homes - Milestones / impact	H22	Yes
Red Bag Scheme - Milestones / impact	H27	Yes

Sheet Complete:	Yes

6. Integration Highlights ^^ Link Back to top

	Cell Reference	Checker
Integration success story highlight over the past quarter	B10	Yes
Main Scheme/Service type for the integration success story highlight	C13	Yes
Integration success story highlight over the past quarter, if "other" scheme	C14	Yes
Main Enabler for Integration (SCIE Integration Logic Model) for the integration success story highlight	C17	Yes
Integration success story highlight over the past quarter, if "other" integration enabler	C18	Yes

Sheet Complete:	Yes

7. Winter Pressures Grant

^^ Link Back to top

	Cell Reference	Checker
Brief narrative on progress in delivering the Winter Pressures Grant spending plan	B8	Yes
Indication whether the planned spend for the Winter Pressures Grant is on track	C10	Yes
Where "NOT ON TRACK", please indicate actions being planned or in place to get back on track	C11	Yes
Have acute hospital trusts continued to be involved in the delivery of the Winter Pressure Grant plan?	C13	Yes
Please describe how this involvement is being ensured	C14	Yes

Sheet Complete:	Yes

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3. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Cumbria

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	

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4. Metrics

Selected Health and Wellbeing Board: Cumbria

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	Assessment of progress against the metric plan for the quarter	Challenges and any Support Needs	Achievements
NEA	Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population	Data not available to assess progress	Non-elective admissions rates have a strong performance against its strategic benchmark. However, there is continued pressure on urgent and elective care systems throughout Cumbria. Howver full Q3 data not available	The work that the A&E delivery boards have been and will continue to have close working relationships at strategic level. The focus that they have had on a whole-system approaches to the joint ownership of the challenge has seen improvements.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	In Qtr3 2019/20 the rate of permanent admissions of older people to residential and nursing care homes was 175.5 per 100,000 persons over 65 years old; a increase from 169.0 in Qtr2 2019/20. The actual number of	Although for this quarter the rate is slightly above target, for the year as a whole the average is currently within the set target. Cumbria has set itself a very challenging target for 19/20 and despite the pressures
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	In Qtr3 there were 89.58% of people who were at home on day 91 following a period of reablement, below the target of 91%. This overall measure has been maintained throughout the last quarter, with	The current performance is within 2% of the target. Cumbria performamce compares well with available comparative data and over the course of the year has seen steady improvement
Delayed Transfers of Care	Average Number of People Delayed in a Transfer of Care per Day (daily delays)	Data not available to assess progress	Validated Qtr3 data is not yet available (published in February). The number of delayed days in July was 2,517 ; in August the number was 3,830 ; in September the number of delayed days was 3,307	A high level review of the business intelligence assurance processes has been undertaken to ensure that we are reporting DTOCs accurately. As part of this process Delayed Transfers of Care between the Acute

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5. High Impact Change Model

Selected Health and Wellbeing Board: Cumbria

Challenges and Support Needs — Please describe the key challenges faced by your system in the implementation of this change, and Please indicate any support that may help to facilitate or accelerate 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

			Narrative		
		Q3 19/20	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges and any Support Needs	Milestones met during the quarter / Observed impact
Chg 1	Early discharge planning	Established		No Place Like Home has been rolled out as a campaign across North Cumbria. There has been varied uptake levels at each acute site, and teams are focused on training and process review to improve this. The Integrated Discharge Team, which has encountered workforce challenges, will be well placed to support this work once they are fully operational again. Across Morecambe Bay, the SAFER programme requires support to fully embedd across the acute Trust. In addition, patient transport systems (PTS) for discharges continue to be challenged, mainly due to multiple vehicles 'out of area', which impacts on capacity. In addition, over the past quarter there has been an increased cost pressure for private ambulances for 'Home First' patients. Also, work needs to be undertaken to support family engagement when selecting a care home and the subsequent care package capacity to facilitate discharge. Morecambe Bay continue to request support from the Council's ASC Team to	Tripartite working arrangements in Morecambe Bay are focused on addressing patient transport system needs, to support the identification of discharge solutions. In North Cumbria, Integrated Care Community (ICC) hub coordinators are based on each acute site, working closely with discharge teams (where these are in place) and wards to facilitate discharges. ICC Cliniciansare also working on both sites to support admission prevention and discharge planning. In addition, the No Place Like home initiative has been rolled out to all wards which includes early discharge planning. This campaign is also piloting leaflets on one particular ward, to measure its effectivines to meet care aims and objectives.
Chg 2	Systems to monitor patient flow	Established		Dashboards that enable real time monitoring for DTOC and MFFD would be an enabler for improvement work. Also, there is an identified need to develop EMS+ across OOH services and	Acute Trusts continue to report against key metrics such as ED flow, DTOCs, % performance, Triage rate, Discharges, EDD, MFFD etc.
Chg 3	Multi-disciplinary/multi-agency discharge teams	Established		Challenges centre around the time required to bring all parties together to continue on the Integrated Discharge Team meetings. This is an ongoing piece of work and is moving forwards in line	Across South Cumbria, ICAT and Care Co-Ordination Hubs continue to develop and evidence cross organisational work. Furthermore, strategic level conversations are still ongoing to
Chg 4	Home first/discharge to assess	Established		Recruitment challenges remain from all funding pots. A business case for 2020/21 is due to be considered for Morcambe Bay in February 2020. No additional challenges or support needs have been identified at this time. The effectiveness of teams is monitored, so as to properly embed the service and maximise utilisation.	In North Cumbria, a range of options to enable discharge to assess are in place to meet a variety of patient needs including the Home First and Home from Hospital teams. Home First team and discharge to assess is in place across the Morecambe Bay CCG footprint, with emerging evidence for success. In addition, the North Lancashire ICAT Project Team has been established across the Bay Footprint for a number of months. Cumbria Care are working with UHMBT to formally take over all social care bridging patients as part of thier Reablement / Domicilary Care packages. The initial transfer occurred 31st July 2019 but work continues via weekly escalation calls to ensure these opportunites are maximised.

Chg 5	**Seven-day service**	Established		There are difficulties across independent sector for weekend discharges in South Cumbria, plus there are challenges across all pathways to standardise across both Lancashire and Cumbria to ensure efficiency. Recruitment for the pharmacy teams, to support 7 day working in West Cumbria, is due to take place but expected to be challenged. Furthermore, there are continued workforce pressures within primary care arena, including dififculties in recruiting ANPs for Out Of Hours support.	Proposal for Kendal Urgent Treatment Centre to be open for a 7 days serive has been support by Cumbria Health on Call. Cumbria County Council reablement and support at home is provided 24 hours a day, 7 days a week, and domiciliary care services are provided during the night also. Additionally, each ICC has 7 day working in place. with comprehensive extended access provision from primary care. The 7 day pharmacy service commenced in Cumberland Infirmary Carlisle, and the service should also be opened for 7 days in West Cumberland Hospital, Whivehaven, by 1 April 2020. There is currently an active pilot focused on discharges during the weekend, which is being spearheaded by Cumbria Health on Call. This pilot will remain active for a number of months to assess its effectiveness.
Chg 6	**Trusted assessors**	Plans in place		Due to workforce pressures within the North Cumbria Integrated Discharge Team, there has been slippage in operationalising plans. This remains a key focus for the ICCs and A&D Delivery Board, who continue to work strategically together to introduce improvements to systems. Operational plans will continue to be implemented once the Integrated Discharge Team is fully operational again. Across South Lakes, Age UK have withdrawn funding for this programme of work, which has produced challenges.	Carers Assessments are in place for the entire area. In North Cumbria, the interim bed pathway includes a trusted assessment by the the Trust's Occupational Therapy Team, ensuring that the care home manager does not need to visit the acute to assess the individual's suitability of a placement. There is focus on operationalising trusted assessors for the Burnrigg and Gables Cumbria Care beds, which is to be kept under review and learnings will be shared more widely across Cumbria. In South Lakes, LCC has trusted assessment into Home First, Reablement and Equipment services.
Chg 7	**Focus on choice**	Established		In North Cumbria, the Integrated Discharge Team are key to fully realising the benefits of Supporting People to Make Choices to Avoid Long Hospital Stays policy - as they will be able to champion and drive forward the use of the policy, through providing education and support to colleagues within the system. Once the team are fully operational again, the team will be asked to focus support on this policy, to support system-wide improvements.	The Supporting People to Make Choices to Avoid Long Hospital Stays policy is being utilised on the acute sites throughout North Cumbria. In South Lakes, the Home of Choise policy is in place and actively utilised - wards commence discharge planning from point of admission and Care Home Select offers a care home brokerage service. Information leaflets to be distributed at point of admission. Feedback analysis from the friends and family feedback to be reviewed to identify recommcendations for future improvement.
Chg 8	**Enhancing health in care homes**	Established		Primary Care links with Care Homes have previously been challenged, as specific care homes are not linked to a speific GP pracitce. However, operating in Primary Care Networks has provided a more coordinated and reliable approach to enhancing health in care homes, which has minimised many of the challenges previously experienced, and has allowed for improvement planning to take place.	Cumbria has benchmarked well, from data provided by North West Ambulance Service, reporting that Cumbria care homes tend to be much lower users of 999 services than elsewhere in the North West. The specifications are due to be issued in North Cumbria. ICCs have been working with Prmary Care Networks on the self-assessment framework in order to appropriately prepare them for the specification roll out. In Morecambe Bay, initial work has commenced in respect of developing a CCG strategy for the regulated care sector and this will include evaluation of current service provision as well as some short term evidence based projects. The focus is on developing a preventative agenda. There is also a falls lifting service pilot in place across North Lancashire and Grange ICC developed wrap around service model for replication.

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.					
		Q3 19/20 (Current)	**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**
UEC	**Red Bag scheme**	Established		In North Cumbria, there have been some reported incidents regarding poor awareness of red bags within the acut ehospital, which has impacted on its use. However, this has been recognised and training will take place with ward staff within the Trust, to maximise use of the red bags.	All care homes in North Cumbria now have red bags and are using them. Ambulance crews have been provided with appropriate training and are familiar with their use.

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6. Integration Highlight

Selected Health and Wellbeing Board:	Cumbria

Remaining Characters:	17,535

Integration success story highlight over the past quarter:
Please give us an example of an integration success story observed over the past quarter. This could highlight system level collaborative approaches, collaborative services/schemes or any work to progress the enablers for integration (as per the SCIE logic model for integrated care). Please include any observed or anticipated impact in this example.

There have been several highlights from the past quarter, as a result of integrated working. Some of these examples include:
• Integration around supporting people with dementia, including: Improved integrated approaches via local ICC weekly MDTs (attended by GPs, district nursing, social workers, CPNs); Joint approaches to care home sector including integrated early warning meetings, to support and improve quality of care home provision; Joint education and training initiatives as well as regular joint meetings to enhance communication; Collaborative working via CHESS (Care Home Education & Support Service) to work closely with care homes, improving quality and maintenance of placements.

Additionally, the Mental Helth Team have worked closely with North Cumbria Integrated Care NHS Foundation Trust, to roll out Attend Anywhere, which enables the provision of remote consultation services to our patients. As Cumbria is one of the largest geographical regions in England and has a large number of isolated communities with transport chellenges, this step forward using technology has resulted in improved patient experience throuhgout the locality. In addition, it has supported integration of our health and care teams through the using the system for Multi-Disciplinary Team meetings, connecting us together when travel challenges had previously presented this.

Finally, one specific example, which has been closely followed by the public and staff is as follows:
Within one of the North Cumbria ICCs, a patient with very complex needs under the care of the District Nursing Team decided to withdraw their treatment (venilation) and publically announced this through the media. Working with the Palliative Consultant, Hospice team, Legal Services, Communications Team, District Nurses, Respiratory Consultant, CHC, Carers, and the Coroner, the ICC staff worked with the patient and their family to put a care package in place that provided regularly contact and discussion with the patient. This plan was active in the 8 weeks prior to the decision taking effect. Working together meant that the patient died with dignity at home in accordance with their wishes. Psychological support was accessed and offered to the family. The ICC held a debrief for the staff afterwards where staff were able to share memories of the patient. Currently there are plans to develop palliative services within the ICC on the back of these new links established.

Where this example is relevant to a scheme / service type, please select the main service type alongside or a brief description if this is "Other".

Scheme/service type	Personalised Care at Home
Brief outline if "Other (or multiple schemes)"	

Where this example is relevant to progressing a particular Enabler for Integration (from the SCIE Integration Logic Model), please select the main enabler alongside.

SCIE Enablers list	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-
Brief outline if "Other"	

Better Care Fund Template Q3 2019/20

7. Winter Pressures Grant

Selected Health and Wellbeing Board:	Cumbria

Please provide a brief narrative on progress made towards delivering the Winter Pressures Grant spending plan (as expressed within the BCF planning template 2019-20)

The Winter Pressures Grant is funding in the region of 2,500 support at home hours per week. Winter Pressures measures continue to be disvussed at A&E Delivery Boards. The commitment remains to reduce the number of service users in NHS settings waiting for social care where possible. Where possible there has been optimisation of resources inlcuding the deployment of staff to improve performance.

Please indicate whether the planned spend for the Winter Pressures Grant is on track	On Track
Where "NOT ON TRACK", please indicate actions being planned or in place to get back on track	

Have local acute hospital trusts continued to be involved in delivery of the Winter Pressures Grant including any changes in the use of the grant as compared to 2018-19?	Yes
Where 'No' is selected above, please describe how this involvement is being ensured	