Nottinghamshire County Council

Report to the Health and Wellbeing Board

05 June 2019

Agenda Item: 10

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION, NOTTINGHAMSHIRE COUNTY COUNCIL

2018/19 BETTER CARE FUND PERFORMANCE

Purpose of the Report

1. This report sets out progress to date against the Nottinghamshire Better Care Fund (BCF) plan and requests that the Health and Wellbeing Board:

    1.1. Approve the Q4 2018/19 national quarterly performance report.

Information and Advice

Performance Update and National Reporting

2. Performance against the BCF performance metrics and financial expenditure and savings continues to be monitored monthly through the BCF Finance, Planning and Performance sub-group and the BCF Steering Group.

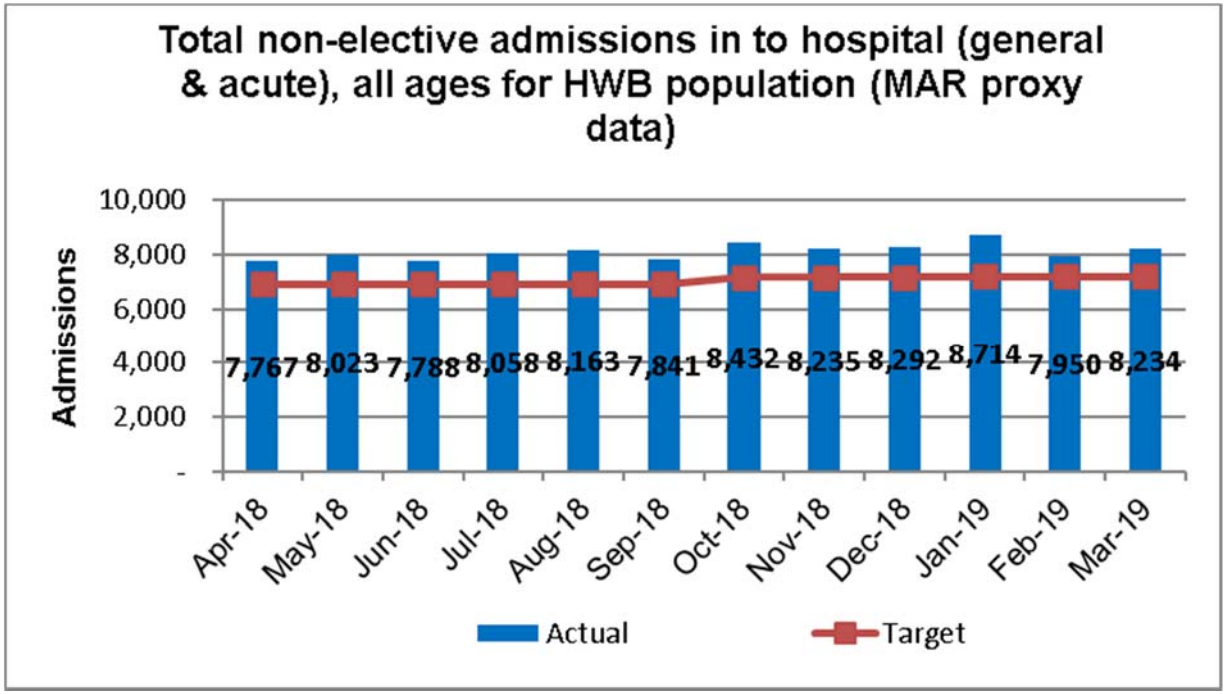
3. The performance update includes delivery against the six key performance indicators, the financial expenditure and savings, scheme delivery and risks to delivery for Q4 2018/19.

4. This update also includes the Q4 2018/19 national quarterly performance template submitted to the NHS England Better Care Support Team for approval by the Board.

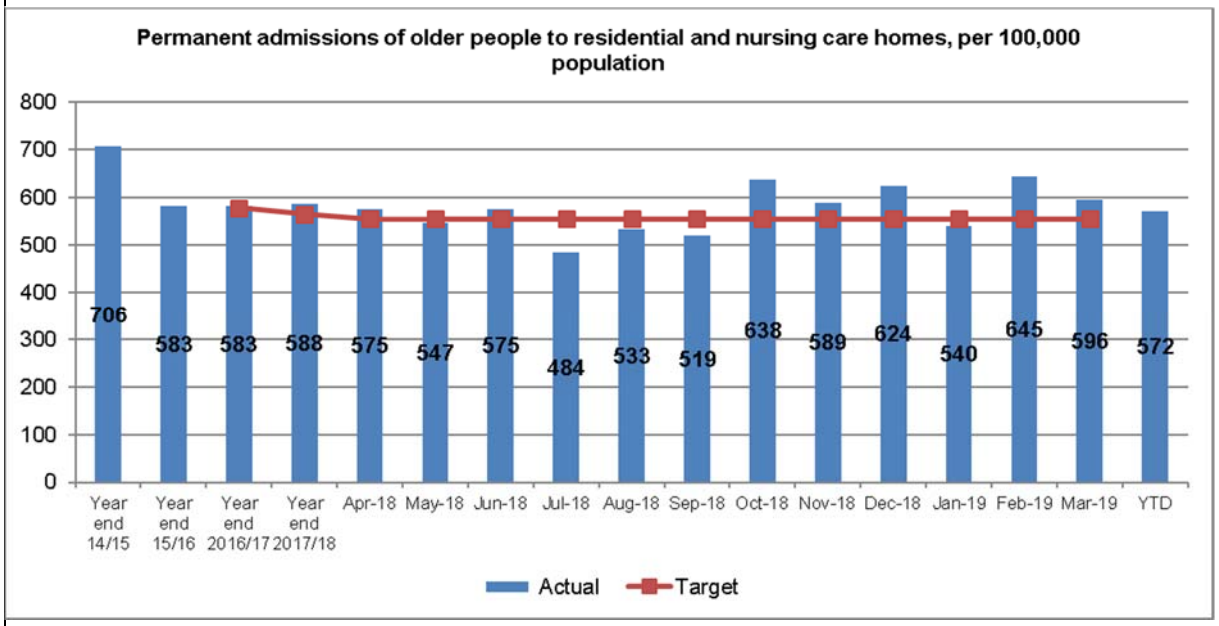
5. Q4 2018/19 performance metrics are shown in Table 1 below.

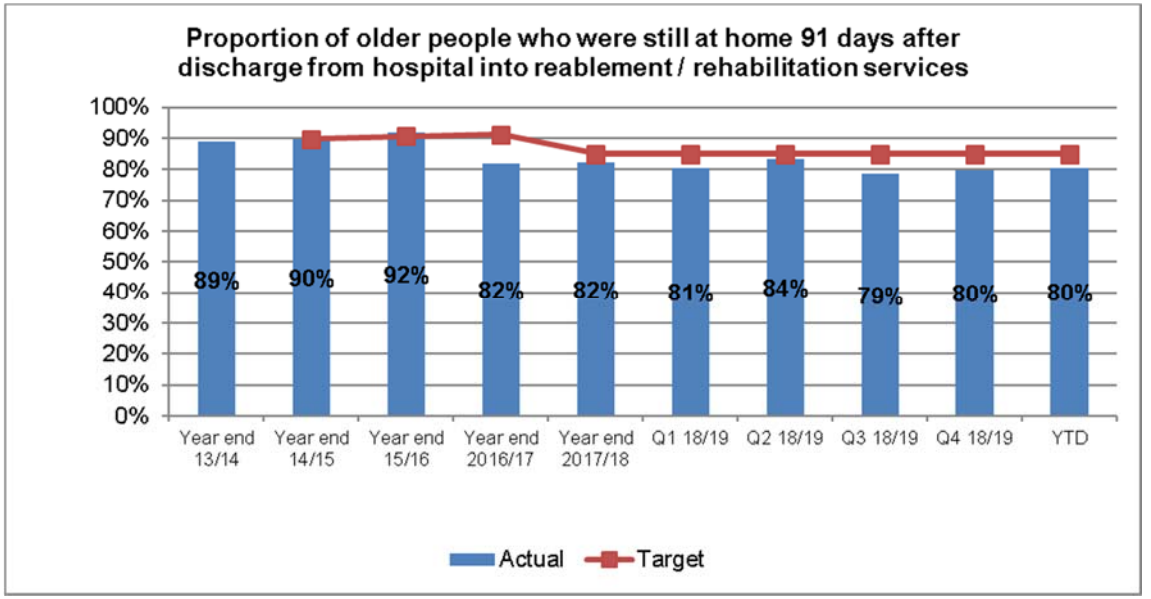
    5.1. Two indicators are on track.
    5.2. Four indicators are off track and actions are in place.

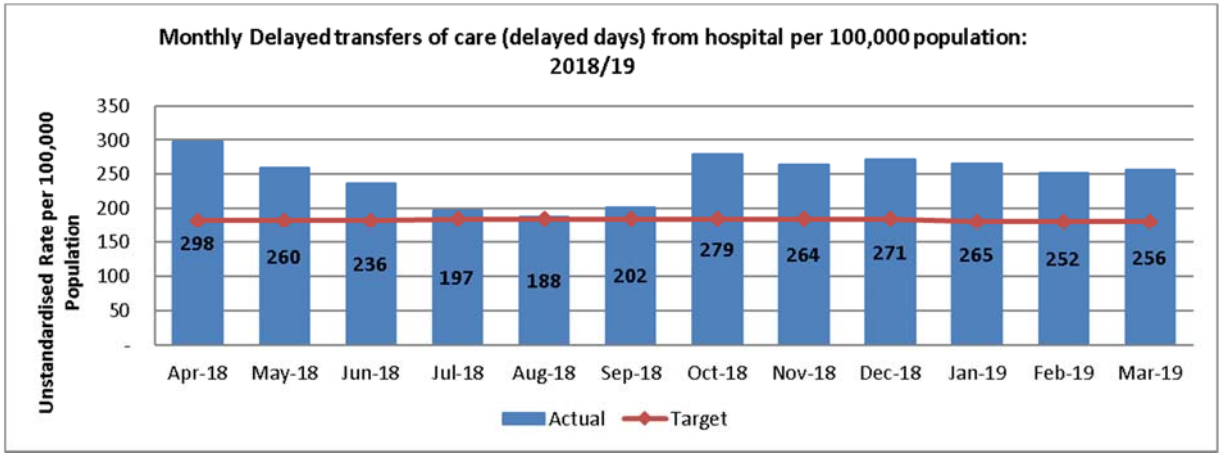
Table 1: Performance against BCF performance metrics

REF	Indicator	2018/19 Target	2018/19 Actual	RAG and trend	Key issues and mitigating actions
BCF 1	Total non-elective admissions in to hospital (general & acute), all-age	21,583 Q4	24,898 Q4	Red ⇔	 **South:** Paediatric admissions for South Nottinghamshire CCGs are 58.6% higher than the agreed contractual plan with NUH in the year-to-date to January. In this same period, general surgery activity is 28.6% and respiratory activity is 20.4% above the contractual plan agreed with NUH. Year-to-date to January 2019, South Nottinghamshire CCGs are exceeding the CCG operating plans for non-elective admissions with a zero-day length-of-stay by 20.9%. A key driver is paediatric patients aged 0-4 years with a step change in admissions clearly seen from December 2017. This issue has been raised formally with NUH through the contractual process. Projects are in place to support admission avoidance: Care Co-ordination is predominantly focused on the reduction of readmission and

					identification of patients with 5 or more long-term conditions. The scheme will build on existing Primary Care Networks to embed a consistent care co-ordination approach to admission avoidance by identifying care gaps and utilising evidence-based interventions. A performance dashboard has been developed for Commissioners to monitor outputs from services, onward referral services and linkages to commissioned community activity. A project will also focus on high volume service users who are frequent attenders to urgent care services. The project will focus on three main categories of patients – frailty, long-term conditions, and mental health/alcohol – and will encompass social prescribing, care gap analysis as well as health coaching in some locality areas. Locality Leads have also been identified and regularly review Ambulatory Care-Sensitive emergency admissions and implement actions at a PCN/Locality level. **Mid Notts:** At M10 Year on year there has been a 3.0% growth in total non-elective spells for Mid-Notts. However, 0-day LoS non-elective spells have grown by 10.6%. Analysis indicates that this is attributable to the growth in Ambulatory Emergency Care (AECU) activity and is expected in-line with provider and CCG transformation plans to increase this activity. It is also in keeping with the NHS Long Term Plan ambitions for one third of emergency admissions to be discharged on the same day. Mid Notts are now achieving this target. Work is taking place across both mid-Notts and the ICS to reduce activity at the front door, for example the EMAS non-conveyance group, the Proactive Care Homes Service and the Acute Home Visiting service. The mid-Notts CCGs review levels of high activity at individual practice level and manage with practices as appropriate. QIPP schemes are monitored closely and additional schemes are developed where possible. This has included extending the current COPD scheme to include further cohorts of patients and a scheme which will proactively manage those at risk of deterioration in care homes (Significant Seven). A new A&E 'pull team' is continuing into Q4 and there is evidence of benefits of community staff working with hospital staff in A&E to discharge patients home with support. The second trial of in-hours GP cover in A&E to support the pull team and PC24 has taken place and is currently being evaluated outcomes for these pilots are expected in time for the next update report. **North:**

					Admissions for pneumonia, COPD, heart failure, urology and sepsis are all higher than planned and higher than last year. Additional work is been undertaken regarding respiratory conditions as part of the Urgent Care Board as a task and finish group led by the Chief Nurse, with a deep dive into the diagnosis data being carried out. Emergency readmissions within 30 days of discharge are also significantly higher than planned. Further analysis is being undertaken on the admission diagnosis to understand where the main increases lie.
BCF 2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	555	572	Amber ⇧	 - Monitored by Nottinghamshire County Council ASCH&PP and the Older Adults Delivery Group. - Admissions' reporting has a time input lag factor for each calendar month, for example, admissions at the end of the calendar month will likely not be input in time and therefore the figure requires revision. This means that the previous months admissions rates will usually increase upon revision the next month. - This data is provisional (national data published annually). - Long term admissions to residential or nursing care have increased slightly this year as the council faces increased demand from people with complex needs. Improvement actions include: - All requests for placements are considered by Team Managers/Group Managers to ensure that all alternative options to promote the person's independence have been

					explored. - Promoting Independence Meetings are being rolled out across Older Adults Services. These are meetings of peers to reflect on cases and share new ideas on how to promote people's independence and manage risk. Dashboard local performance information enables teams to have up-to-date information to support them driving their own continuous improvement. - A Strategic Commissioning Programme is underway to develop alternative services that have an evidence base for reducing the use of residential care. This includes, Housing with Care, Short Term Assessment and Re-ablement Apartments and Assistive Technology.
BCF 3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85%	80%	**Red** ⇔	 To have met the additional 5% required to achieve the target for this year would have, in terms of numbers of people, required an additional 20-30 people to have still been at home 91 days after a re-ablement intervention. The main reasons for not reaching 85% were: - In line with the Adult Social Care Strategy to maximize people's independence, re-ablement at is now being offered to more people with higher, multiple complex needs. This reduces the proportion of people for whom it is fully successful. - The Council's directly provided (Short Term Assessment and Re-ablement Team (START) service visits people in their own homes and has an outcome of 89% at year-end for this indication. People with higher needs, however, may require accommodation based re-ablement, for example provided in residential care home

					setting for which outcomes are naturally lower. - Data is not yet been collected from all the right services. Improvement actions include: - Actions to automate data collection from the correct set of services. - Work with other LAs to benchmark, seeking ways to improve service outcomes and set realistic yet ambitions future targets. - Major project underway to increase re-ablement capacity across both home and accommodation-based services to enable more people to be re-abled.
BCF 4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	542.2 Q4	772.8 Q4	**Red** ⇔	 **South:** There are several key actions that are currently being taken to improve the performance of this metric, namely: - Work to reduce LOS in hospital. - Review of community bed capacity. - A joint health and social care review of homecare in Nottingham City seeking to address issues of insufficient homecare capacity to take cases in a timely way at point of discharge. - Work to implement Phase 3 of the Integrated Discharge function, which includes elements operating 7-days across the system. - The development of a Countywide Care Home Bed capacity system. **Mid Notts:** - The rollout of the care home capacity tracker is underway in Mid-Notts, along with Red Bags for Care Homes, both of which are designed to reduce Length of Stay and

					DToCs. - Collaborative working continues to take place across Nottinghamshire, for example, the D2A lead from Greater Nottinghamshire is working collaboratively with the Emergency Care Network Manager in mid-Notts to address OOA (out of area) patients and differing discharge pathways. - SFHFT continue to drive #Longstaywednesday – a scheme whereby the Deputy COO & an MDT group visit all 3 bedded SFHFT sites & review all patients with a stay of 21+ days. - The discharge policy at SFHFT is under revision and when ratified and embedded will support a reduction in DToCs with regards to patient choice, and not allowing patient choice to include staying in hospital longer than is clinically necessary. - The CCG has begun to work with SFHFT to explore Multi-Agency Discharge Events (MADE) and whether the Mid-Notts system will benefit from these sessions locally. - Social Care colleagues are now attending daily hub meetings. - SFHFT has gone live with the Nerve Centre E- Beds module - embedded during Q4. - SFHFT are recording the Estimate Date of Discharge (EDD) at all 3 sites. Internal weekly reporting is in place to show the % of patients with an EDD, by ward, and the % of patients discharged on their EDD, by ward. **North:** North Nottinghamshire was successful with its bid to NHS Digital to roll out the sharing of records technology already in place in Mid Nottinghamshire.
BCF 5	Percentage of users satisfied that the adaptations met their identified needs	95%	tbc	tbc	
BCF 6	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions	22%	14%	**Green** ⇧	

					 Extremely positive progress has been made on this indicator. This is in line with increasing numbers of people being discharged from hospital prior to having an assessment and needing to make decisions about their future longer-term care and support needs (known as Discharge to Assess models). National work suggests that there is scope for further reductions in future years. Research undertaken by the Institute for Public Care, (2018 'Reducing Delays in Hospital Transfers of Care for Older People) projects that the numbers of people moving into permanent residential care as a new admission following a hospital episode should, following some form of rehabilitation, be very low at less than 4% of all new hospital admissions. Those people who cannot go directly home from hospital for their re-ablement, are moved into short term beds (e.g. Discharge to Assess, Rehabilitation beds) and increasingly the emphasis will need to include monitoring the outcomes of these services in terms of numbers of people who return to their own home.

6. Expenditure was on plan for 2018/19, except for a £49k overspend in the Handy Person Adaptation Service as shown in Table 2 below. This overspend was met by the main Adult Social Care Department budget.

Table 2: 2018/19 BCF Expenditure

	Planned Spend	**Spend**	**Variance**
Nottinghamshire Clinical Commissioning Groups (CCGs)	£32,129,147	£32,129,147	£0
Protecting Social Care	£17,057,413	£17,057,413	£0
Carers	£1,268,544	£1,268,544	£0
Care Act Implementation	£2,060,996	£2,060,996	£0
Improved Better Care Fund	£21,590,371	£21,590,371	£0
Disabled Facilities Grant (District and Borough Councils)	£6,441,437	£6,490,434	-£48,997
TOTAL	£80,547,909	£80,596,905	-£48,997

7. The BCF Finance, Planning and Performance subgroup monitors all risks to BCF delivery on a quarterly basis and highlights those scored as a high risk to the Steering Group. The Steering Group has agreed the risks on the exception report as being those to escalate to the HWB (Table 3).

Table 3: Risk Register

Risk id	**Risk description**	**Residual score**	**Mitigating actions**
BCF005	There is a risk that acute activity reductions do not materialize at required rate due to schemes not delivering the intended outcomes, and/or unanticipated cost pressures and/or impact from patients registered to other CCG's not within or part of Nottinghamshire's BCF plans.	16	- Monthly monitoring through BCF Steering Group and BCF Finance, Planning and Performance subgroup as well as local governance forums. - Mid Notts Alliance Oversight Board, A&E Board and Better Together Proactive and Urgent workstream leads providing substantial focus.
BCF009	There is a risk that the available workforce does not meet the volume or skills required for the scale of transformation required or the future system needs.	9	- Monthly monitoring through A&E Delivery Boards, System Resilience Group and Transformation Boards. - Workforce development plan in place, including a succession plan. - Discussion with regional workforce teams to facilitate long term recruitment and development planning. Review recruitment and retention plans (annual). - Reduce scale of services and/or phase delivery to accommodate extend recruitment timescales. - Use of locum staff to bridge gaps.

BCF012	There is a risk that the target for the BCF2 metric (care home admissions) will not be met at year end and that this will not be known until late in-year due to how data is reported (retrospectively amended).	9	-All requests for placements are considered by Team Managers/Group Managers to ensure that all alternative options to promote the person's independence have been explored. - Promoting Independence Meetings are being rolled out across Older Adults Services. - A Strategic Commissioning Programme is underway to develop alternative services that have an evidence base for reducing the use of residential care. - Retrospective data amendment and the lack of a pattern in terms of the numbers of monthly admissions, can make it difficult to predict if the number of admissions will be on target by year end. The NCC Performance Team will work with managers to identify if there are any sustainable improvements to data predictions.
BCF014	There is a risk that the DTOC target will not be met in 2018/19.	16	Further action is needed to review issues such as housing, weekend discharge and liaison with A&E Delivery Boards.
BCF016	There is a risk that the target for BCF 3 (reablement 91 days) of 85% will not be achieved at year end.	12	This indicator is monitored at both the NCC Performance Board and the Older Adults Interventions board. There is an action plan in place to address issues with specific districts and service providers.

8. The Q4 2018/19 national report was submitted to NHS England on 18 April pending HWB approval (Appendix 1). Due to the timing of the report, the content for Nottinghamshire County was prepared and agreed by the BCF Finance, Planning and Performance sub-group and approved by the BCF Steering Group. If the HWB requests amendments to the report, the quarterly report will be resubmitted to the NHS England Better Care Support Team.

9. Further national reporting is due on a quarterly interval with dates to be confirmed.

Other options

10. None.

Reasons for Recommendations

11. To ensure the HWB has oversight of progress with the BCF plan and can discharge its national obligations for reporting.

Statutory and Policy Implications

12. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

13. The £80.5m BCF allocation for 2018/19 is fully spent.

Human Resources Implications

14. There are no Human Resources implications contained within the content of this report.

Legal Implications

15. The Care Act facilitates the establishment of the BCF by providing a mechanism to make the sharing of NHS funding with local authorities mandatory. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected.

RECOMMENDATIONS

That the Board:

1. Approve the Q4 2018/19 national quarterly performance report.

Melanie Brooks
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Constitutional Comments (KK 23/05/2019)

16. The proposal in this report is within the remit of the Health and Wellbeing Board

Financial Comments (OC 14/05/2019/2019)

17. The financial implications are within the table below and detailed through-out this report.

Q4 Pooled Budget 2018/19 £'000s	**Planned Spend**	**Actual Spend**	**Variance**
Nottinghamshire Clinical Commissioning Groups	£32,129,147	£32,129,147	
Protecting Social Care	£17,057,413	£17,057,413	£0
Support for Carers	£1,268,544	£1,268,544	£0
Care Act Implementation	£2,060,996	£2,060,996	£0
Improved Better Care Fund	£21,590,371	£21,590,371	£0
Disabled Facilities Grant (District and Borough Councils)	£6,441,437	£6,490,434	-£48,997
Total	£80,547,909	£80,596,905	-£48,997

Background Papers and Published Document

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local

Government Act 1972.

Better Care Fund: Proposed Allocation of Care Act Funding – report to Adult Social Care and Health Committee on 12 September 2016

Better Care Fund Performance and 2017/19 Plan – report to Health and Wellbeing Board on 28 June 2017

Integration and Better Care Fund planning requirements for 2017-19, Departments of Health, and Communities and Local Government, 3 July 2017

Proposals for the Use of the Improved Better Care Fund – report to Adult Social Care and Public Health Committee on 10 July 2017

Approval for the Use in In-Year Improved Better Care Fund Temporary Funding – report to Adult Social Care and Public Health Committee on 13 November 2017

Better Care Fund: 2017/18 Progress Update and Approval for the Use of the BCF Care Act Allocation and the Improved BCF 2018/19 – report to Health and Wellbeing Board on 7 March 2018

Better Care Fund Performance (2017/18) – report to Health and Wellbeing Board on 6 June 2018

2018/19 Progress Update and Approval for the Use of the BCF Care Act Allocation (Recurrent and Reserve), the Improved BCF, and the Winter Pressures Grant 2019/20 – report to Health and Wellbeing Board on 6 March 2019

2019/20 Better Care Fund Policy Framework, Department of Health & Social Care, 10 April 2019

Quarterly reporting from Local Authorities to the Department of Health & Social Care in relation to the Better Care Fund, Quarter 4 Return – 18 April 2019

Electoral Divisions and Members Affected

All.

See also Chair's Report items:

58. 2019-2020 Better Care Fund: policy framework.

Appendix 1

Better Care Fund Template Q4 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Nottinghamshire

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

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q4 2018/19

Metrics

Selected Health and Wellbeing Board: Nottinghamshire

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
NEA	Reduction in non-elective admissions	Not on track to meet target	NORTH: M1-M11 = 640 admissions over plan. Emergency Care over performance is both activity and casemix complexity driven. Admissions for pneumonia, COPD, heart failure, urology and sepsis are all	NORTH: Additional work is been undertaken regarding Respiratory conditions as part of the Urgent Care Board as a task and finish group led by the Chief Nurse.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Managing admissions to care homes continues to present a challenge as the Council faces increased demand from people with more critical needs. This year over the winter period the level of	Permanent admissions to LTC continue to be monitored by the Senior Leadership Team on a monthly basis and all new admissions are checked and approved at panel meetings by Group Managers.
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	Short term reablement support is now offered to people with more critical needs. This has meant that the target of 85% is extremely challenging. The percentage still at home after 91 days has	Reablement services supporting hospital discharge have expanded this year following implementation of the Home First Response Service and increased capacity within START. More people are
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	NORTH: Delayed Transfers for NCC residents at Bassetlaw Hospital has been on a downward trend throughout the year.	NORTH: Data sharing technology between Bassetlaw Hospitals Emergency Department and the Council was implemented in November 2018.

Better Care Fund Template Q4 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board:	Nottinghamshire
Challenges	Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact	Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs	Please indicate any support that may better facilitate or accelerate the implementation of this change

		Q4 18/19 (Current)	Challenges	Milestones met during the quarter / Observed impact
Chg 1	**Early discharge planning**	Established	North: Interoperability Phase 1 now established with positive feedback from ward staff utilising the system. Benefits analysis of the Phase 1 implementation is ongoing, further work required with IDT and ED staff group. Mid: The Home First Integrated Discharge work stream has experienced further delays and has not yet gone live. The ambition for the project now is to go live in Q1 19/20. There is evidence that patients are not being referred to Social Care early enough, and that there are some inappropriate referrals being made. This is being addressed between Social Care & SFHFT colleagues. Conversations with Primary Care indicate that elective discharge planning does not happen in Primary Care robustly. South: Increase in P2&3 bed requests. Previous agreement to progress the Lancashire model, but now due to funding this is unable to be progressed at the moment. Greater focus required to support P1 - home care.	North: IDT (Health and Social care professionals) now provide services on a Saturday. Community services have attended the daily IDT meetings since the beginning of January with a recent review to maximise effectiveness. A weekly Length of Stay review has been introduced to support current winter pressures. The monthly Length of Stay meeting will continue with themes identified to escalate. Ongoing discussions with voluntary sector regarding interfacing with wards to support discharge planning. Following a Quality Improvement Event for Trauma and Orthopaedics, subsequent workshops identified a pilot to facilitate/expedite the pathway for patients with fractured necks of femur. This is currently being evaluated. Social Care staff for ED now part of and based within the Integrated Discharge Team. An electronic Bed Management System has been introduced on each ward at Bassetlaw Hospital which indicates and updates the Estimated Discharge Date. Mid: The Discharge Policy is in final draft for partner sign off and end May 19 implementation. HFID "live" assessment day completed by all partner agencies which will result in a report for further discussion and action.

				South: - Emergency admissions have a predicated discharge date set within 48hrs of being admitted and are identified as being a “simple” or “supported discharge”. - 250+ supported discharges weekly. DTOC currently 3.2% and is low in comparison to previous winter months. - Average length of stay post Medically Stable for Discharge @ 2.2days. - Joint DTOC coding Standard Operating Procedure continues across all organisations. - Red bag scheme in operation across the South. - Front Door Discharge team work holistically (trained through Citycare competencies framework) and refer direct to START and Leivers accept “Transfer of Care” form for admission to Leivers Court. - County Social Care Home First Response Service 7-day service to bridge capacity of Homecare and START.
Chg 2	**Systems to monitor patient flow**	Established	North: EMS Plus Licence is being reviewed by DBTH, potential that the EMS Plus system will no longer be used, currently awaiting further information. Transport issues effecting discharge, they are logged and formally and escalated for solution. Mid: A key piece of work is the STP demand & capacity work which has been delayed. Internal bed modelling work has taken place at SFHFT to provide a seasonal bed model requirement. The system's Surge & Escalation plan details triggers for identifying increased demand and bottlenecks together with actions at each OPEL level. Social care has produced a demand and capacity function which has allowed the system to have sight of available resource. The system winter plan will become a system seasonal plan, which will account for seasonal fluctuations in demand and capacity which is key to patient flow. South: Dashboard and system flow in place, but currently a manual process across the system. Access for system partners to care home bed system in a timely manner is required to improve visibility of capacity and flow.	North: Discharge Coordinators feedback from all wards during IDT morning meetings. Demand management, escalations plans in place to increase external bed/care options to reduce DToC when the hospital is on high alert. During winter pressures, there is now a weekly LOS review. IDT lead reps attend a daily operational flow meeting. There is a live web-based portal system which details all the available care home beds in the Bassetlaw Health and Social Care system. Care homes update the system on a regular daily basis, with information available to the CCG, Social Care, acute and community staff. The system supports a more rapid discharge into the care home sector. A Bed Management System has now been introduced with plans to roll out to Doncaster Royal Infirmary and Mexborough Hospital which will further improve system flow. Demand for intermediate care beds has outweighed capacity which has led to the introduction of winter pressure beds across the Bassetlaw PLACE. The EMS Plus Escalation system is used to identify capacity to support patients across the system and identify need for escalation to senior managers. Mid: SFHFT have been working to embed the Nervecentre beds e-module. A review of the SFHFT discharge hub was

				undertaken, which has identified the need for a more focussed meeting. This will be picked up as part of the HFID project. The work stream has also commenced conversations with Local Authority partners to identify discharge pathways for 'non-health delays' e.g. (hoarding, broken boilers etc) to reduce delays in this area. System calls have taken place when the system has experienced pressures & A&E Delivery Board has reviewed performance and flow each month. South: - County Social Care Team now have access to nerve centre on their laptops via VDI apps, giving staff direct access to NUH data to view and edit. - Phased plans to further roll out remote access to Nerve Centre across the community. - Interoperability project at NUH underway to automate Assessment and Discharge Notices for County Social Care. Delivery timescales now confirmed with phase 1/wave 1 w/c 22/4, phase 1 wave 2 Sept 19. - Care Home Bed capacity system is progressing with all care homes signed up through NHS England, work now needed to progress getting all homes live on the system and access for partners.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Countywide Summary: All three acute health systems meet the 'established' criteria, some aspects of 'mature' and have plans to further develop and improve their multi-agency discharge arrangements. North: Develop greater links with Care homes. Develop acute community interface with the 3 Primary Care Networks (Homes) in Bassetlaw with the aim of 'pulling patients' through their discharge pathway. Community involvement with daily IDT morning triage meetings to review and pull out patients from the wards to discharge directly back into the community to receive Rehab at home. Community involvement in daily ward rounds presence in ED to reduce hospital admission. Mid: Mid-Notts have a jointly written PID for 19/20 where system partners have agreed to mobilise an	North: 3rd Sector are now working in a joint approach with BDGH/IDT, Community Health and Social care to facilitate quality discharge to reduce readmission and reduce the need for statutory services. Mid: Social Care are attending the SFHFT discharge hub. Social Care have delivered a demand & capacity OPEL dashboard for system visibility. Home First Response service is in place. The NECS Care home bed tracker & Trusted Assessor will also provide additional insight & support to existing collaborative working nature of the Mid-Notts system. System providers work collaboratively with elements of integration, despite there being no single organisational structure. South: - Weekly long patient stay review in place by senior partners.

			integrated rapid response service (IRRS) which will include community, social care and acute colleagues working in a much more integrated way in ED and on the wards. South: Challenges to maintain the reduction of DSTs in hospital to <15%. Work progressing with stroke to reduce the requests for DSTs and mental health patients. Commissioning decision needed to explore increasing community stroke beds and reduce DTOC.	- Transfer Action Groups within NUH across the Divisions are in place.
Chg 4	**Home first/discharge to assess**	Established	North: START are now accepting referrals from all teams and health staff via a trusted assessor model which may result in a reduced START service response time. There is a need to develop an agreed home first pathway for intense rehabilitation from base wards as Rapid Response is only commissioned for front door transfers. Mid: We continue to remain at Plans in Place (Although we are already meeting some of the established & mature criteria) due to the slippage of the Home First Integrated Discharge scheme which has a Home First philosophy and in which specific pathways are identified to support care delivery outside of the acute setting. South: Increased demand for home care package as part of Home First. For D2A, increased prevalence of flu, diarrhoea is affecting community bed capacity. Maintain utilisation of community capacity.	North: The Fact Find document is used to facilitate the discharge to assess model, to make direct referrals as part of timely hospital discharge where the community care assessment is then completed external to the hospital site, e.g. START services and Assessment beds at James Hince Court. There is an established discharge to assess framework in place to support the discharge of patients who may require assessment for CHC funding. START no longer use RAG rating status which allows staff to refer patients directly. Several care homes are now accepting the trusted assessment for transfer which negates the need for care home staff to attend the hospital. No DSTs are completed on the hospital setting, assessments are completed via the Short-Term Nursing Beds pathway, beds at external residential settings are funding by the CCG with MDT involvement as part of the assessment process. Mid: A "live" assessment workshop has been completed by partners with an expected report and further actions to be agreed regarding next steps. The "hub" will be revised and a visible system (similar to the front-end flow room) is to be established across April and May. The over 21 and 7-day patient process is under review and a proposal is drafted. South: - Weekly supported discharge target of 250 has been consistently achieved. - Home First ethos being embedded and leaflet developed. - Reduction in medically safe for transfer around 130. - Reduction in daily DTOCs to 3.1%. - Trusted Assessment in place - further phase 2 training

				being planned. - Winter resilience funding used to support Home First / D2A.
Chg 5	**Seven-day service**	Established	North: IDT staff currently work over 6 days and cover bank holidays, plan to review IDT 7 day working requirements linked to capacity and demand. Care Home communication is ongoing with regards to accepting referrals/decision making for patients over 7 days. Emergency Department cover over 7 days by Social Care staff. Mid: HFID did not go live in Q4 & this is intended to support improvements in advance planning of discharges. Improvements will better enable the home care providers more notice in re-starting POC over weekends. The new Home First Response Service funded by social care can respond within 24 hours providing capacity is available. There have been challenges around the content of the SFHFT discharge policy around generic board & ward rounds taking place consistently over weekends. South: Workforce change to support 7-day services. Whilst some services are in place to support 7-day working it is recognised there are gaps.	North: The Social care and health staff in the IDT currently provide a 6-day service which is being presently being evaluated. Positive results have already been reported regarding LOS and the efficiency of the discharge pathway. All current new posts have 7-day working as part of their contract. Home First Response service accept referrals over 7 days. START service development is ongoing with regards to the provision of a 7-day service linked to accepting referrals. Mid: As a system we are already displaying examples of mature & exemplary. Call for Care community service operates over the weekend, along with transport providers, hospital social care teams. South: - IDT provide the service 6 days a week (includes Sunday). - Home First group looking at how to get to a 7 day integrated discharge function across the system. - County Social Care have a rota system in place to cover weekend working. - Work ongoing to develop 7/7 service for IDT in NUH.
Chg 6	**Trusted assessors**	Established	North: Systemwide development approach required, for ward/IDT staff/Residential care. Continue to monitor and improve. Continue to embed the trusted assessor model with local care homes. Mid: There continues to be no appetite locally for the utilisation of a single form, or for health to assess on behalf of Social Care, but partners continue to review opportunities to streamline working processes moving forwards. Some health organisations assess on behalf of other health organisations e.g. IDAT for CFC & vice versa. On this basis we are unlikely to be able to commit to	North: This is an ongoing development to move from some care providers to all care providers/Care homes being signed up the Trusted assessor model. Bassetlaw hospital IDT operate a trusted assessor model of work using a multi-agency staff group using a single assessment/referral document which is accepted by other community bed-based providers and OOA providers. Mid: System partners continue to work closely and as collaboratively as possible, Social Care have been attending the SFHFT discharge hub at the request of SFHFT.

			achieving Mature of Exemplary. The TA pilot has ended with little robust evidence available to support the commissioning of this post on a substantive basis due to low referral numbers. South: Recruitment challenges in NUH for Trusted Assessor at NUHT.	South: Trusted assessor scheme being led by Nottinghamshire County Council on behalf of the Integrated Care System through BCF funding until March2019. Pilot at Sherwood Forest Hospital now finished and evaluation due to be shared with SFHT and wider system partners in April 19. NUH recruitment was unsuccessful in September / October 2018, and decision made not re-recruit due to BCF funding ending in March.
Chg 7	**Focus on choice**	Established	North: The IDT focus on choice is an integral part of the discharge discussion at all stages, however there is no formal Choice Protocol in place. Mid: The revised discharge policy is not currently in place and this will need to be embedded for mid-Notts to declare a 'Mature' status. Pt. Choice focus & distribution of letters isn't robust without this being in place. HFID not currently live to be able to capture full discharge pathways in the discharge policy. Not all the homes who are signed up to the NECS care home bed tracker are keeping their information/details updated which is key to the success of the programme. The CCG is working with Notts CC care home contract leads to address this. South: Continual support for staff when implementing the discharge policy. Implementation challenges in the community.	North: Within DBTH a Discharge Passport is given to all patients who are admitted to hospital, providing relevant information regarding the hospital admission and discharge process pathways. The content of the passport is currently being reviewed to reflect new developments linked to discharge pathways. Mid: The SFHFT discharge policy is in final draft form & will be embedded in May 2019. Patient Choice will be a strong focus of this document. An STP-wide patient leaflet is distributed to patients upon admission to SFHFT. This enables early discharge conversations and forms the basis on which patient choice conversations will take place moving forwards. It will be supported by the discharge policy & sets patient & family expectations in terms of timeframes/circumstances someone can expect to remain in the acute trust. Work is actively taking place between SFHFT & Social Care partners to improve the uptake of interim care offers within the SFHFT patient cohort. Notice letters are sent out to patients where appropriate. The NECs care home bed tracker has proceeded at pace in Notts & this will enable patients, families & carers to make faster decisions around care home selections. The revised DToC guidance has been considered by mid-Notts partners and will be applied to DToCs from 01 April 2019. A key element of this is the change from acute trust attributable DToCs to Social Care attributable DToCs for declined offers of care home placements when home-based POC are not available. This will ensure that the relevant organisation will be able to positively influence the DToC solutions for these patients.

				South: - Training programme in place since October 2018; training included as part of Excellence and Discharge Programme. - New joint approach of social worker and ward staff to implement the policy, reinforcing collective message and consistency. - Review of policy in April 2019.
Chg 8	**Enhancing health in care homes**	Established	North: The 3 Primary Care Networks in Bassetlaw are at different development stages and as part of this development is the need for consistent GP links with Bassetlaw care homes to reduce ED presentation/GP appointments, increase health and well-being within care homes etc. Mid: CQC status of homes is variable. South: Enhanced care service to care homes in County. Review of service for Nottingham City who decommissioned their enhanced service from 1 April 2018. Need to monitor if any impact, i.e. increased ED activity.	North: Bassetlaw CCG holds care home forums twice yearly to influence and inform care home development, linked to hospital admission avoidance and facilitating hospital discharge; these forums also offer joint training sessions. The local authority quality market management team continually work with local Residential/Nursing care homes to raise standards and the quality of care within those homes, through announced and un-announced audit visits. Mid: Care Home admissions continue to be low as per the target for mid-Nottinghamshire & this was part of the feedback from the Senior A&E Consultant at the mid-Nottinghamshire A&E Delivery Board winter de-brief session. The 111 service will go live with offering the Call for Care Non-injury Falls Pathway to patients - previously this has only been available to EMAS, which will reduce unwarranted urgent care system activity & offer greater support to care homes. SFHFT are part of the Frailty network & a work stream is in place to strategically address frailty from A&E throughout patient flow areas & to amalgamate all projects which will impact on frailty e.g. Significant 7. Notts Healthcare Trust Proactive Care Homes & NEMs colleagues are undertaking RESPECT Training this week. Bi-monthly meetings between the EoL Head of Service & The CCG Care Homes Lead take place to ensure alignment of work programmes. South: - STP Urgent & Emergency Care Group agreed to prioritise 'frequent activity' in all areas, which includes care homes. - Spot purchase care home bed framework and escalation being operationalised, to provide additional community bed capacity in times of escalation and greater community

				bed demands. - ED activity in care homes has reduced.

		Q4 18/19 (Current)	Challenges	Achievements / Impact
UEC	**Red Bag scheme**	Established	Mid: No new challenges identified, however the project team will be meeting to monitor for unintended consequences & to undertake a PDSA review of the rollout to date. South: Ongoing work to ensure repatriation of red bags to care homes following the death of a resident in hospital.	North: The Red Bag scheme has been fully implemented in Bassetlaw care homes. The scheme provides continuity of care and aims to reduce length of stay by ensuring a smooth and effective transfer from the hospital back to the care homes. Mid: Bags have been rolled out to all care homes & engagement work has been completed. No reports of lost bags to date. Positive feedback from A&E & EMAS colleagues that bags are being utilised across mid-Notts. South: Red bag scheme rolled out across Greater Nottingham care homes on 02.10.2017. All frail older patient care homes aware and engaging with project. Many using the red bag as well as all the accompanying paperwork such as CARES escalation record.

Better Care Fund Template Q4 2018/19

5. Income and Expenditure

Selected Health and Wellbeing Board: Nottinghamshire

Income

	2018/19	
Disabled Facilities Grant	£ 6,441,437	
Improved Better Care Fund	£ 21,590,371	
CCG Minimum Fund	£ 52,516,100	
Minimum Sub Total		£ 80,547,908

	Planned		Actual		
CCG Additional Fund	£ -		Do you wish to change your additional actual CCG funding?	No	
LA Additional Fund	£ -		Do you wish to change your additional actual LA funding?	No	
Additional Sub Total		£ -			£ -

	Planned 18/19	Actual 18/19
Total BCF Pooled Fund	£ 80,547,908	£ 80,547,908

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2018/19	

Expenditure

	2018/19
Plan	£ 80,547,909

Do you wish to change your actual BCF expenditure?	No

Actual	£ 80,547,909

Better Care Fund Template Q4 2018/19

6. Year End Feedback

Selected Health and Wellbeing Board: Nottinghamshire

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Partners agreed this at our annual BCF evaluation event.
2. Our BCF schemes were implemented as planned in 2018/19	Agree	Majority of programme delivered as planned, some rephasing of initiatives in year.
3. The delivery of our BCF plan in 2018/19 had a positive impact on the integration of health and social care in our locality	Agree	BCF programme evaluated positively.
4. The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Non-Elective Admissions	Agree	Avoided admissions attributable to initiatives across the system including BCF schemes, however challenges remain.
5. The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	Reductions in DToCs in summer, increase in winter. Management of levels of DToCs is attributable to initiatives across the system including BCF schemes.
6. The delivery of our BCF plan in 2018/19 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after	Agree	Short term reablement support is now offered to people with more critical needs. This has meant that the target of 85% is extremely challenging. The percentage still at home after 91 days has been consistently reported at around 80% this year, 5% under target.

discharge from hospital into reablement/rehabilitation services		
7. The delivery of our BCF plan in 2018/19 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	Maintenance of levels of residential care is attributable to initiatives across the system including BCF schemes.

Part 2: Successes and Challenges
Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2018/19.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	2. Strong, system-wide governance and systems leadership	Nottingham/Nottinghamshire and Bassetlaw/South Yorkshire were both chosen to be among the first areas in the country to develop Integrated Care Systems (ICS). These provide greater opportunities to manage local services and invest in what is known to work best for local people; such as focusing on preventing illnesses and providing more services near to where people live, or improved identification of people at risk of stroke - resulting in the prevention of 44 strokes and avoidance of 12 potential deaths in Nottingham/Nottinghamshire. The Notts ICS has also been chosen as 1 of 3 national pilot sites for a joint approach to assessments, support plans and reviews - integrating budgets and care around individuals.
Success 2	3. Integrated electronic records and sharing across the system with service users	ICT solutions have facilitated the electronic sharing of social care service user information with health professionals in 2 NHS Trusts. This is saving administrative resources and improving response times and the quality of referrals from health to social care.

9. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2018/19.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	Demographic trends are driving increases in both the number and complexity of cases. This coupled with reducing national allocations of funding in Local Government is exerting financial pressures on the system to match capacity.
Challenge 2	6. Good quality and sustainable provider market that can meet demand	Difficulties recruiting and retaining staff to key posts is a challenge for both acute and community health providers, as well as social care. There are significant difficulties recruiting enough homecare staff to meet demand.

Better Care Fund Template Q4 2018/19

7. Narrative

Selected Health and Wellbeing Board: Nottinghamshire

Remaining Characters:	18,784

Progress against local plan for integration of health and social care

In Nottinghamshire we have maintained our ambition for a strong BCF plan across our Health and Wellbeing Board footprint. Performance against all BCF metrics continues to be monitored monthly to ensure timely actions where plans are off-track. There continues to be a high level of commitment from partners to address performance issues e.g. daily discussions within hospitals to facilitate timely discharges, the development of transfer to assess models to reduce long term admissions to care homes, District Authority alignment with Integrated Discharge Teams to ensure housing needs of patients are addressed prior to discharge and avoid unnecessary delays.

The 6 CCGs continue to work with local authority, District and Borough Councils, acute, mental health and community trusts and the community and voluntary sector in their 3 units of planning to ensure service transformation with a focus on reducing non-elective admissions and attendance, and care home admissions. Plans to accelerate improvement in trajectories are forecast to deliver further improvements as projects and programmes mature and transfer of investment and resources to primary and community setting manages demand more appropriately.

Remaining Characters:	19,118

Integration success story highlight over the past quarter

In accordance with a Nottingham Trent University evaluation of the conditions required to produce best performance, Integrated Care Teams consisting of Social Workers, Community Care Officers, District Nurses, Fast Track Nurses and Urgent Reponse Clinical Advisors are now being co-located in shared offices. This has proved really successful because it means that social care workers and health staff can quickly swop notes on the cases that are coming through, sharing information from each other's systems and discussing the appropriate action to be taken in an integrated way. Case studies show that this new way of working supports people to stay living at home during a crisis, rather than having to be moved into an short-term residential care placement. This is better for the person themselves and can prevent a short-term admission turning into a longer-term placement.

Better Care Fund Template Q4 2018/19

8. Additional improved Better Care Fund: Part 1

Selected Health and Wellbeing Board:	Nottinghamshire
Additional improved Better Care Fund Allocation for 2018/19:	£ 10,026,024

Section A

Distribution of 2018/19 Additional iBCF funding by purpose

At Q1 18/19, it was reported that your additional 2018-19 iBCF funding would be allocated across the three purposes for which it was intended as follows:	a) Meeting adult social care needs	b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready	c) Ensuring that the local social care provider market is supported
(Percentages shown in these cells are automatically populated based on Q1 18/19 return):	55%	16%	29%

A1) Do you wish to revise the percentages provided at Q1 18/19 as shown above? Please select "Yes" or "No" using the drop-down options:	Yes

	a) Meeting adult social care needs	b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready	c) Ensuring that the local social care provider market is supported	If submitting revised figures, percentages must sum to 100% exactly
A2) If you have answered 'Yes' to Question A1, please enter the revised amount for each purpose as a percentage of the additional iBCF funding you have been allocated for the whole of 2018/19. If the expenditure covers more than one purpose, please categorise it according to the primary purpose. You should ensure that the sum of the percentage figures entered totals to 100% exactly. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell. If you have answered "No" to Question A1, please leave these cells blank.	58%	14%	28%	100%

Successes and challenges associated with additional iBCF funding in 2018/19

Success 1	Success 2	Success 3

A3) Please use the options provided to identify your 3 key areas of success associated with the additional iBCF funding during 2018/19. Hover over this cell to view the comment box for the list of options if the drop-down menu is not visible. Aside from "Other", please do not select an option more than once.	Reducing DTOC	Prevention	Health and social care integration
A4) If you have answered Question A3 with 'Other', please specify. Please do not use more than 50 characters.			
A5) You can add some brief commentary on your key successes if you wish. Please do not use more than 200 characters.	Reablement (START) and Home First services, along with integrated discharge teams, contributed to maintaining social care DTOCs within the top-10 lowest levels in the country.	BCF-supported prevention/early intervention/enabling services (NES, Connect, Moving Forward & Brighter Futures) helped to maintain and develop the independence of approximately 9,250 service users.	Several IT projects are enabling data sharing, shared record viewing, system integration and data analytics across health and social care.

Challenge 1	Challenge 2	Challenge 3

A6) Please use the options provided to identify your 3 key areas of challenge associated with the additional iBCF funding during 2018/19. Hover over this cell to view the comment box for the list of options if the drop-down menu is not visible. Aside from 'Other', please do not select an option more than once.	Workforce – recruitment	Tackling DTOC	Managing demand
A7) If you have answered Question A6 with 'Other', please specify. Please do not use more than 50 characters.			
A8) You can add some brief commentary on your key successes if you wish. Please do not use more than 200 characters.	Temporary budget allocations and short planning timescales exacerbate difficulties with recruitment within a tight labour market.	DTOCs for health reasons are above target and challenging due to admissions increases.	Rising demographic led demand for packages of support for people with very complex needs.

Section B

At Q1 18/19 it was reported that your additional iBCF funding would be used to support the following initiatives/projects in 2018/19

	Initiative / Project 1	Initiative / Project 2	Initiative / Project 3	Initiative / Project 4	Initiative / Project 5	Initiative / Project 6	Initiative / Project 7	Initiative / Project 8	Initiative / Project 9	Initiative / Project 10
Project title (automatically populated based on Q1 18/19 return):	Meeting demand in younger adults' services	New models of social care provider services required to implement Home First and Discharge to Assess	National Living Wage increases and inflation for Fair Price for Care	Social care assessors in hospital integrated discharge services	Innovation through ICT solutions - sharing information across health and social care organisations	Additional capacity to quality assure and meet increasing demand in statutory/safeguarding work	Prevention services to build community resilience and offer early interventions (Brighter Futures, Connect, Co-Production, Moving Forward)	Independence building services to offer and develop alternative low and no cost community provision (Notts Enabling Service)	Improving the quality of care home and home care provision (Quality & Market Management Team)	Improving the management of demand and risk by offering appropriate early interventions (3-Tier Model)
Project category (automatically populated based on Q1 18/19 return)	1. Capacity: Increasing capacity	3. DTOC: Reducing delayed transfers of care	16. Stabilising social care provider market - fees uplift	3. DTOC: Reducing delayed transfers of care	7. Integration	12. Protection	11. Prevention	11. Prevention	12. Protection	5. Managing Demand
B1) If a project title is shown in either of the two rows above, use the drop-down options provided or type in one of the following options to report on progress to date: Planning stage In progress: no results yet In progress: showing results Completed Project no longer being implemented	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results	In progress: showing results

Better Care Fund Template Q4 2018/19

9. Additional improved Better Care Fund: Part 2

Selected Health and Wellbeing Board:	Nottinghamshire
Additional improved Better Care Fund Allocation for 2018/19:	£ 10,026,024

Section C

	a) The number of home care packages provided in 2018/19 as a result of your addition iBCF funding allocation	b) The number of hours of home care provided in 2018/19 as a result of your additional iBCF funding allocation	c) The number of care home placements for the whole of 2018/19 as a result of your additional iBCF funding allocation

C1) Provide figures on the actual number of home care packages, hours of home care and number of care home placements you purchased / provided as a direct result of your additional iBCF funding allocation for 2018-19. The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please enter 0 in the appropriate box.	395	0	84
C2) If you have not increased the number of packages or placements, please indicate **the main area** that you have spent the **addition iBCF funding allocation** for 2018/19. Hover over this cell to view the comment box for the list of options if the drop-down menu is not visible.			
C3) If you have answered C2 with 'Other', please specify. Please do not use more than 50 characters.			

Section D

Metrics used locally to assess impact of additional iBCF funding 2018/19

	Metric 1	Metric 2	Metric 3	Metric 4
Metric (automatically populated based on Q1 18/19 return):	Sustain DToCs attributable to social care at or below 0.7.	Increased numbers of service users reabled following a period of acute care.	Increased numbers of service users able to maintain independence by using prevention services.	Reduced number of Care and Support Assessments (CASAs) to mitigate the predicted increased number of people who receive long term care packages.

D1) Additional Metric Name **If the cell above is blank, you can provide details of an additional metric. If you did not submit any metrics at Q1 18/19, please ensure you have provided details of at least one metric. You can provide details of up to 5 metrics in total based on your combined Q1 18/19 and Q4 18/19 returns e.g. if you submitted 3 metrics at Q1 18/19, you can submit an additional 2 metrics.** Please do not use more than 100 characters to describe any additional metrics.				
D2) If a metric is shown in either of the two rows above, use the drop-down menu provided or type in one of the categories listed to indicate which of the following categories the metric primarily falls under. Hover over this cell to view the comment box for the list of categories if drop-down options are not visible.	DTOC/Discharge	DTOC/Discharge	Prevention/Early intervention/Signposting	Prevention/Early intervention/Signposting
D3) If you have answered D2 with 'Other', please specify. Please do not use more than 50 characters.				
D4) If a metric is shown above, use the drop-down options provided or type in one of the following options to report on the overall direction of travel during the reporting year: Improvement No change Deterioration Not yet able to report	Improvement	Improvement	Improvement	Improvement