Nottinghamshire County Council

Report to the Health and Wellbeing Board

5 September 2018

Agenda Item: 10

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

BETTER CARE FUND PERFORMANCE AND 2018/19 PLAN

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:

   - Approve the Q1 2018/19 national quarterly performance report.
   - Approve the amendments made to the 2018/19 plan to refresh the performance targets in-line with agreed amendments to organisational targets.

Information and Advice

Performance Update and National Reporting

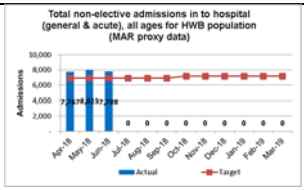
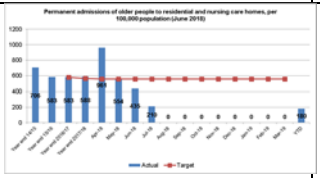
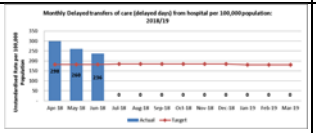
2. Performance against the BCF performance metrics and financial expenditure and savings continues to be monitored on a monthly basis through the BCF Finance, Planning and Performance sub-group and the BCF Steering Group.

3. The performance update includes delivery against the six key performance indicators, the financial expenditure and savings, scheme delivery and risks to delivery for Q1 2018/19

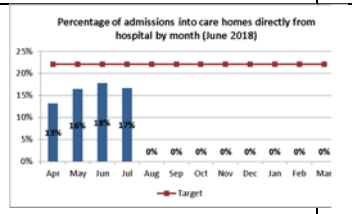
4. This update also includes the Q1 2018/19 national quarterly performance template submitted to the NHS England Better Care Support Team for approval by the Board. This report has taken a new format and consolidates the BCF and Improved BCF quarterly returns.

5. Q1 2018/19 performance metrics are shown in Table 1 below. Targets are yet to be determined.

Table 1: Performance against BCF performance metrics

REF	Indicator	2018/19 Targets (pro-visional)	2018/19	RAG and trend	Trend	Summary of mitigating actions
BCF1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	20,763 Q1	23,578 Q1	R ⇩		South CCGs have seen growth in emergency admissions in 2017/18. Largely, the activity increase for the South CCGs has been seen within the short stay activity at NUH. Granular analysis has identified that the volume of recorded admissions has been impacted by the implementation of a pathway change within the emergency department. This has led to an increase in admissions for patients requiring further assessment or diagnostic tests. Mid and North CCGs have seen a reduction in activity.
BCF2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	555.4	650 Q1	R ⇔		Long term admissions to residential or nursing care have increased this year as the council faces increased demand from people with complexed needs. All placements are considered at panel and agreed where there is no viable alternative.
BCF3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85%	81% Q1	R ⇩		The percentage of people still at home after 91 days has reduced as reablement type services available upon discharge from hospital have expanded and are now offered to people with more critical needs.
BCF4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	548.2 Q1	794.15 Q1	R ⇧		**South** A regional DToC Plan has been produced and trajectories established. Regional actions to be taken to reduce DToCs include but are not limited to: encouraging active participation in the operational management of discharge,

REF	Indicator	2018/19 Targets (pro-visional)	2018/19	RAG and trend	Trend	Summary of mitigating actions
						development of a discharge hub approach, effective implementation of a patient choice policy, Home First workbooks in Nottinghamshire and development of the Red Bag initiative. **Mid** • Commenced weekly meetings focussing on integrated discharge transformation scheme/programme • Commenced Better Together discharge initiative whereby Board Rounds are attended by Social Care and Community Services as well as the Discharge Team on the pilot wards. • Mobilised a D2A pathway into community teams/services in M&A **North** Using short term nursing care beds to ensure that DSTs aren't being done in hospital • Bassetlaw CCG is liaising and working with the Local Authority to facilitate discharges which are out of the CHC pathway • Delays are discussed at the Urgent Care Operations Group fortnightly to resolve local issues that are not covered by routine processes • Integrated Discharge Team at Bassetlaw Hospital works well with Local Authorities.
BCF5	Percentage of users satisfied that the adaptations met their identified needs	95%	100% Q1	G ⇔	⇔	

REF	Indicator	2018/19 Targets (pro-visional)	2018/19	RAG and trend	Trend	Summary of mitigating actions
BCF6	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes	22.11%	15.1% Q1	G ⇔		

6. Reconciliation of Q1 2018/19 spend is complete. Expenditure is broadly on target with some in year slippage. Table 2 shows plan and forecast as at Month 3

Table 2: 2018/19 spend at month 3

Contributing partner	**Nottinghamshire Clinical Commissioning Groups (CCGs)**	**Nottinghamshire County Council**	**Total**
£'000s			
Payments made into pooled budget	£13,129,025	£11,839,030	£24,968,055
Payments received from pooled budget	£8,032,287	£16,935,768	£24,968,055
Total spend to period 3	£8,032,287	£16,739,866	£24,772,153
Under/(over) spend to period 3	£0	-£195,902	£195,903

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 2).

Table 3: Risk Register

Risk id	**Risk description**	**Residual score**	**Mitigating actions**
BCF005	There is a risk that acute activity reductions do not materialise at required rate due to delays in scheme implementation, unanticipated cost pressures and impact from patients registered to other CCG's not within or part of Nottinghamshire's BCF plans.	16	Monthly monitoring of non-elective activity by BCF Finance, Planning and Performance subgroup and Steering Group (currently only for activity in Nottinghamshire CCGs). Oversight by A&E Delivery Boards.
BCF009	There is a risk of insufficient recruitment of qualified and skilled staff to meet demand of community service staffing and new services; where staff are recruited there is a risk that existing service provision is destabilised.	16	Monthly monitoring through A&E Delivery Boards and Transformation Boards. Workforce and organisational development identified as a Sustainability and Transformation Partnership (STP) priority.
BCF14	There is a risk that the DTOC target will not be met in 2017/18.	16	Advice to the system being given on counting to ensure accurate reporting. Actions being taken forward by A&E Delivery Boards.

8. As agreed at the meeting on 7 October 2015, the Q1 2018/19 national report was submitted to NHS England on 20 July 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.

BCF 2018/19

10. The Board agreed the BCF plan covering 2017-2019.

11. On 20 July 2018 BCF Operating Guidance for 2018/19 was published. In summary there are no changes to the policy framework, planning guidance or conditions. However, metric targets are to be refreshed for 2018/19.

12. The BCF Steering Group reviewed the proposed targets for the metrics and submitted these as a draft on 24 August 2018. The changes proposed for consideration by the Board are:

- The BCF 2017-19 plan remains as agreed and there are no substantial changes to BCF schemes.
- The non-elective hospital admissions performance target is refreshed to align with CCG plans. The target will be as follows:

	2017/18	2018/19 old	2018/19 new
Q1	22,356	22,356	20,763
Q2	22,110	22,110	20,767
Q3	22,817	22,817	21,490
Q4	22,795	22,795	21,583

- The DTOC target is refreshed in line with published targets:

	2017/18	2018/19 old	2018/19 new
Q1	607.0	597.0	548.23
Q2	613.7	597.0	554.25
Q3	613.7	597.0	554.25
Q4	597.0	597.0	542.20

- The care home admissions target remains as set:

2017/18	2018/19
565.6	555.4

- The reablement target remains as set:

2017/18	2018/19
85%	85%

Other options

13. None.

Reasons for Recommendations

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

Statutory and Policy Implications

15. 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

16. The £80.5m for 2018/19 is forecasting an underspend at month 3 of £0.78m this relates to the Improved better care fund however it is anticipated to be fully spent at the end of the year.

Human Resources Implications

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

Legal Implications

18. 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 Q1 2018/19 national quarterly performance report.
2. Approve the amendments made to the 2018/19 plan to refresh the performance targets in-line with agreed amendments to organisational targets.

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Constitutional Comments (LM 7/08/18)

19. The Health and Wellbeing Board is the appropriate body to consider the contents of the report.

Financial Comments (OC 8/08/18)

20. The financial implications are contained within paragraphs 5 and 16 of the report.

Background Papers and Published Documents

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: Guidance for the Operationalisation of the BCF in 2015-16". http://www.england.nhs.uk/wp-content/uploads/2015/03/bcf-operationalisation-guidance1516.pdf
- Better Care Fund – Final Plans 2 April 2014
- Better Care Fund – Revised Process 3 June 2014
- Better Care Fund Governance Structure and Pooled Budget 3 December 2014
- Better Care Fund Pooled Budget 4 March 2015
- Better Care Fund Performance and Update 3 June 2015
- BCF Performance and Finance exception report - Month 3 2015/16
- Better Care Fund Performance and Update 7 October 2015
- Letter to Health and Wellbeing Board Chairs 16 October 2015 from Department of Health and Department of Communities and Local Government "Better Care Fund 2016-17"
- Better Care Fund Performance and Update 2 December 2015
- 2016/17 Better Care Fund: Policy Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf
- Better Care Fund Performance and Update 2 March 2016
- Better Care Fund 2016/17 Plan 6 April 2016
- Better Care Fund Performance and Update 6 June 2016
- Better care fund Performance, 2016/17 plan and update 7 September 2016
- Better Care Fund Performance 7 December 2016
- Better Care Fund Performance March 2017

See also Chairs Report items:
62. Beyond barriers: how older people move between health and care in England.
66. Improving communication between care homes and hospitals
67. System under strain: Why demand pressures are more than a winter phenomenon
69. The Integration and Better Care Fund operating guidance for 2017-19.

Electoral Divisions and Members Affected

- All.

Appendix 1

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		

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Data not available to assess progress	South Nottinghamshire CCGs have seen growth in emergency admissions in 18/19. Largely, the activity increase has been seen within the short stay activity at NUH. Analysis highlights that the increase in admissions is driven by Paediatrics, Respiratory Medicine and General Surgery. Respiratory medicine activity is 30% higher than the agreed contractual plan at May YTD, with COPD and Pneumonia being the key drivers at a diagnosis level. The seasonal demand for respiratory care has continued for a longer period into Spring and early summer. North Nottinghamshire are slightly over plan at Month 2. Currently carrying out some investigative work as to main drivers for this for activity at DBTH. Initial findings have seen an increase in activity and complexity for Heart Failure, Pneumonia, Stroke, Vascular and COPD diagnosis. Mid Nottinghamshire: M2 YTD	Emergency Activity continues to be discussed at both the joint A&E Delivery Boards and the local Systems Resilience Groups. Mid Nottinghamshire: Non-elective activity is discussed at the A&E Delivery Board and supporting groups.	

			SUS: M&A = 3843 v 3765 plan (+2.1%) N&S = 2242 v 2162 plan (+3.7%) The 2 Mid-Notts CCGs are not achieving the SUS plan submitted to the NHSE. The Top 5 specialties over plan at M2 YTD are Acute Internal Medicine, Geriatrics, Stroke, Cardiology and Paediatrics. HRGs over plan include pneumonia, falls and UTIs. "Winter beds" have remained open. Analysis has been undertaken to highlight GP practice levels above the mean. Any exceptions coming out of this analysis, together with the specialties showing high variances will be prioritised as target areas for admission avoidance QIPP schemes. It should be noted that some QIPP schemes required re-phasing to account for Full Year Effect and this was not played into the NHSE SUS plan. If this re-phasing is done, the outcome for M2 YTD is: M&A: -6.2% v plan N&S: -3.9% v plan This has been discussed with the NHSE.		

Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Data not available to assess progress			
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Data not available to assess progress			

Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Data not available to assess progress	Data analysis for Greater Nottingham highlighted that the most common reason for delay in transfers include a lack of capacity in further non-acute NHS care. Other less significant causes of delayed discharge were around completion of assessment and patient or family choice. Mid Nottinghamshire: SFHFT Total Trust (from local data) Apr18 = 885 (national = 5.1%) May18 = 727 (national = 3.9%) Jun18 = 904 There was a significant decrease in May due to discharging of long-stay patients.	The Newton Europe system wide summit in June identified five key areas to be addressed by the system following flow and patient delay diagnostic work. A implementation group is in place, which includes senior leaders to consider how the system can collaborate more effectively. A second system summit is planned for the 24th July. There is also additional focus on reducing the number of patients staying in hospital longer than 21 days , which will contribute towards delivery of a reduction in delayed transfers of care. Mid Nottinghamshire: The Intensive Recovery Roadmap Work Stream has pulled together a system-wide Recovery Plan and this has been ratified by the A&EDB. Progress against the Recovery Plan is overseen by the Intensive Recovery Roadmap Programme Board and issues escalated to the A&E Delivery Board. The first-cut Recovery Plan was completed in April 2018, together with a trajectory to reach 3.5% by September 2018. Actions include: o Ensure coding & reporting of DTOCs accurately reflects national guidance. The Health Community is inviting ECIST back	North Nottinghamshire have submitted a bid to NHS Digital to roll out the sharing of records technology already in place in Mid Nottinghamshire.

				to carry out a review of previous work. o Review of Discharge Policy (which also has a positive impact on the 95% A&E standard) and having clear documented escalation process in place across the system. o Increase proportion of discharges before 11:00am. o Implementation of Trusted Assessor (anticipated Go-Live in July). The DTOC action plan focusses on those patients who are in out-of-area acute hospitals, as well as those in Nottinghamshire hospitals to ensure equity of provision and patient experience. The Mid-Notts Urgent Care team is working closely with the Greater Notts Urgent Care Team and improvements will be approached from an STP footprint perspective wherever possible and appropriate. The Achievement of 3.9% for May 2018 is being considered by the T&F Group in order to replicate 'What Good looks like' wherever possible. The CCG now receives information relating to Stranded Patients and this area will be incorporated into the DTOC Recovery Plan.	

		Maturity Assessment					Narrative			
		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Established	Established	Established	Established	Established	Mid Notts - Rated as 'not yet established' to align with Amber BRAG rating on UEC reporting template.	South Nottinghamshire: over use of P2 pathways due to lack of POC in some areas. Identified care gap for patients with mental health/challenging behaviours - coupled with need to reduce DSTs in hospital. Mid Nottinghamshire: Lack of clear pathway for specific patient cohorts. Intensive	South Nottinghamshire: >250 supported discharges weekly. Reduced DTOC to lowest number ever, as well as reduced MSFD>24hrs. Joint DTOC coding SOP agreed across organisations.Multiagency training 'excellence in discharge planning' "trolley dash" education. Education events planned with NHS Elect for IDF. Mid Nottinghamshire: Work with partners continues Daily hub meetings with external partners. Intensive recovery	South Nottinghamshire: development of the local Lancashire model to promote home first further within a safe and effective system.

								Recovery Roadmap group working on this.	workstream plan in place	
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established	Established		South Nottinghamshire: Nerve Centre live patient flow system. Wider discussions for further IT system support, eg Care Home Bed management & social care system in ED being developed.	South Nottinghamshire: Newton Europe review completed. Clinical Utilisation Review & recommendations completed. Centene work being presented and learning taken to apply into business as usual.	South Nottinghamshire: Embed care home bed management and social care system.

Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Established	Established		South Nottinghamshire: challenges to reduce DSTs in hospital to <15%.	South Nottinghamshire: IDF are working together to ensure appropriate plans are in place for all 'stranded' and super stranded' patients. Thrice weekly health and social care meeting to look at top 20 on medically safe to ensure plans for discharge are in place with accountable lead. Transfer Action Groups within NUH across the Divisons are in place. Weekly complex patient review meeting with senior system partners to 'unlock' any issues with discharge plans.	South Nottinghamshire: Change in culture shift which Excellence in Discharge programme will help to mitigate as will the organisational development work.

Chg 4	**Home first/discharge to assess**	Established	Mature	Mature	Mature	Mature	North Nottinghamshire - No DST's have been completed in hopsital during quarter 1 - robust local process in place.	South Nottinghamshire: Appropriate allocation of pathway and ensuring home first mantra. If not home, why not? Patient groups currently excluded from T2A such as stroke, T&O and need to be included.	South Nottinghamshire: Weekly supported discharge target has been consistently achieved since October 2017. Reduction in medically safe for transfer (from 140-160 down to 100's). Reduction in daily DTOCs following focussed price of work with system partners (from 60-70s down to 30s). Excellence in Discharge training programme commenced in June. Trolley dashes across all wards on both sites are being targeted with drop in sessions. Next phase of this programme will be focussing on community. Weekly complex review meetings take place. Thrice weekly meeting to ensure top 20 on medically safe list have clear	South Nottinghamshire: Change in culture shift which Excellence in Discharge programme will help to mitigate as will the organisational development work.

									plans to enable discharge to happen with accountable leads. Escalation process in place.	
Chg 5	**Seven-day service**	Established	Plans in place	Plans in place	Plans in place	Plans in place		South Nottinghamshire: Whilst some services are in place to support 7-day working it is recognised there are some gaps. North Nottinghamshi	South Nottinghamshire: Provider group working through this to put in place appropriate plans that should come into fruition prior to Winter.	South Nottinghamshire: Development of 7-day services

								re: The Acute trusts needs to review its consultant provisopn over the weekend to support 7 day working		
Chg 6	**Trusted assessors**	Established	Plans in place	Plans in place	Plans in place	Plans in place		South Nottinghamshire: Recruitment to x0.6FTE	South Nottinghamshire: Trusted assessor actions are being led by Notts Healthcare Trust and Nottinghamshire County Council on behalf of the system; 1) recruiting x2 0.6 FTE to support patients returning to their care homes/place of residence, 2) competency development training programme to be implemented from July 2018	South Nottinghamshire: Support development
Chg 7	**Focus on choice**	Established	Established	Established	Established	Established		South Nottinghamshire: Support for staff when implementing the discharge policy.	South Nottinghamshire: Discharge policy for Greater Nottingham is in final draft	South Nottinghamshire: Training will be given across the board with clear escalation process.

Chg 8	**Enhancing health in care homes**	Established	Established	Established	Established	Established				

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.

	Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs

UEC	**Red Bag scheme**	Established	Established	Established	Established	Established		South Nottinghamshire: Return of bags from acute to care home requires further work as current process is not consistently adhered to and gaps identified in the process. Mid Nottinghamshire: Red Bags have been purchased, care homes have undertaken a rollout session as part of Care Homes forum. Key stakeholders (EMAS & SFHFT) have been engaged with and this work is ongoing. Greater Nottsprocesses and	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.	Further funding for additional care homes being built. Repatriation of red bags to the care home.

								paperwork have been reviewed. PMO resource identified in SFHFT. Next steps are too agree paperwork & plan trustwide rollout. at SFHFT		

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.

Integration success story highlight over the past quarter
Housing to Health: Ms B was referred to the project's Housing and Health Coordinator (HHC) by Gedling Borough Council's Environmental Health officer, after the pest control team had visited to deal with a rat infestation that had led to the property's waste pipe being destroyed. The Environmental Health officer was concerned that Ms B was not managing at home, but Ms B wouldn't engage with them. Ms B said that she couldn't afford to make repairs to her home. She had previously attempted to find out more about getting the right benefits, but hadn't been able to get anywhere with this on her own. Ms B had become disengaged with any support services – she regularly leaves the phone off the hook and doesn't answer the door, and also had been cancelling her appointments with her GP for treatment of her leg ulcers. However, the HHC managed to make a home visit with the pest control officer, and arranged a follow up home visit. At this visit, Ms B opened up to the HHC about the true scale of the difficulties she was facing. Her boiler had not worked for over two years and so she had neither hot water nor central heating. HHC noticed fire risks with a defective gas fire and electric cooker. Ms B also asked for help with letters about her finances. Building on her engagement with Ms B, the HHC was able to support her to resolve a number of her issues. The HHC arranged for the Housing to Health's handy person service to get a plumber to fix the waste pipe. The HHC also noticed Ms B's untreated leg ulcers, and called GP who did a home visit the same day. The HHC arranged a joint visit with the fire service, during which smoke and heat detectors were fitted on the visit and other risks discussed. A deep fat fryer has been provided by the fire service free of charge and delivered by the HHC. The HHC was able to sort out an occupational pension and find two other pensions. Ms B subsequently agreed to a call with Age UK to discuss benefits and equity release, and was happy to agree to meet the HHC again with a friend to discuss her finances. In Ms B's case, the housing-related health risks of her living conditions, combined with her reluctance to engage with support services including the GP, meant that there was a high risk of significant health impacts and resulting medical costs. The HHC built up trust with Ms B, finding her the right support before any serious harm occurred. The HHC had the knowledge to connect her to the right services, and provide the one-to-one support that Ms B needed to achieve a positive change in her situation.

Additional improved Better Care Fund Allocation for 2018/19:	£	10,026,024

Section A

What proportion of your additional iBCF funding for 2018-19 are you allocating towards each of the three purposes of the funding?		
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**

Please enter the amount you have designated for each purpose as **a percentage of the total 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. **Please ensure that the sum of the percentage figures entered does not exceed 100%. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell.**	55%	16%	29%

Section B

What initiatives / projects will your additional iBCF funding be used to support 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**
B1) Provide individual titles for no more than 10 initiative / projects. If you are funding more than 10 initiatives / projects, you should list those with the largest	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)

size of investment in 2018-19. Please do not use more than 150 characters.										
B2) Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19? Use the drop-down menu, options below: Continuation New initiative/ project	Continuation	Continuation	Continuation	Continuation	Continuation	Continuation	Continuation	Continuation	Continuation	Continuation

B3) If you have answered question B2 with "Continuation" please provide the name of the project as provided in the 2017-18 returns. See the link above for a reminder of the initiative / project titles submitted in Q4 2017-18. Please do not select the same project title more than once.	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)

B4) If this is a "New Initative / Project" for 2018/19, briefly describe the key objectives / expected outcomes. Please do not use more than 250 characters.										
B5) Use the drop-down menu provided or type in one of the categories listed to indicate which of the following categories the initiative / project	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

primarily falls under. Hover over this cell to view the comment box for the list of categories if drop-down options are not visible.										
B6) If you have answered question B5 with "Other", please specify. Please do not use more than 50 characters.										

B7) What is the planned total duration of each initiative /project? Use the drop-down menu, options below. For continuing projects, you should also include running time before 2018/19. 1) Less than 6 months 2) Between 6 months and 1 year 3) From 1 year up to 2 years	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	4. 2 years or longer	3. From 1 year up to 2 years	4. 2 years or longer	3. From 1 year up to 2 years

4) 2 years or longer										
B8) Use the drop-down options provided or type in one of the following options to report on progress to date: 1) Planning stage 2) In progress: no results yet 3) In progress: showing results 4) Completed	3. In progress: showing results	3. In progress: showing results	4. Completed	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	2. In progress: no results yet	3. In progress: showing results

Section C

What impact does the additional iBCF funding you have been allocated for 2018-19 have on the plans you have made for the following:			
	a) The number of home care packages provided for the whole of 2018-19:	**b) The number of hours of home care provided for the whole of 2018-19:**	**c) The number of care home placements for the whole of 2018-19:**
C1) Provide figures on the planned number of home care packages, hours of home care and number of care home placements you are purchasing/providing 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 could you enter 0 in the appropriate box.	877	-	384

Section D

Indicate no more than five key metrics you will use to assess your performance.					
	Metric 1	**Metric 2**	**Metric 3**	**Metric 4**	**Metric 5**
D1) Provide a list of up to 5 metrics you are measuring yourself against. Please do not use more than 100 characters.	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.	