Better Care Fund Template Q3 2017/18

1. Cover

Version 1

Please Note:

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

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

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

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

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Who signed off the report on behalf of the Health and Wellbeing Board:	Councillor Lynne Caffrey Chair Gateshead Health and Wellbeing Board

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

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

Better Care Fund Template Q3 2017/18

2. National Conditions & s75 Pooled Budget

Selected Health and Well Being Board: Gateshead

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

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	No	Arrangements are progressing to finalise a S75 pooled budget agreement for our BCF 2017-19, similar to the pooled fund arrangements previously in place. A draft has been prepared.	31/01/18

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3. Metrics

Selected Health and Well Being Board: Gateshead

Metric	Definition	Assessment of progress against the planned target for the quarter
NEA	Reduction in non-elective admissions	Data not available to assess progress
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target
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
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	On track to meet target

** Your assessment of progress against the Delayed Transfer of Care target should refle*

Challenges	Achievements	Support Needs
National submission deadlines for BCF template are outside of SUS reporting periods and therefore the full picture for Q3 is not yet available.	Whilst the full quarters data is not yet available for Q3 the non-elective admissions data for Quarters 1 & 2 was circa 9.3% below the planned levels, and	None Identified.
Although aging population still presents a challenge, we are mititgating the risk by our work in transforming community services.	Latest Performance (November 2017) – 495.3 per 100k population (192 admissions). During the period of April to	None Identified.
Although the target has not quite been reached, progress has been seen following service improvements made in Q1.	Latest Performance (April to November 2017) is 85.1%. The indicator value stands at 85.1% (404 out of 475) for all of	None Identified.
Whilst performance in Q3 has been maintained, challenges remain around the fragility of the market.	Latest Performance relates to November 2017. The average number of delays per day, per 100,000 population for	None Identified.

ct progress against the monthly trajectory submitted separately on the DToC trajectory template

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Guidance

Overview

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

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

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cell

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

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

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

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference (hyperlinked) for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear "Red" and contain the word "No" if the information has not been completed. Clicking on the corresponding "Cell Reference" column will link to the incomplete cell for completion. Once completed the checker column will change to "Green" and contain the word "Yes"
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes onfirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 17/19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
- DToC: The BCF plan targets for DToC for the current year 17/18 should be referenced against the agreed trajectory submitted on the separate DToC monthly collection template for 17/18.
The progress narrative should be reported against this agreed monthly trajectory as part of the HWB's plan

When providing the narrative on challenges and achievements, please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.
Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires areas to implement the High Impact Change Model for Managing Transfer of Care. Please identify your local system's current level of maturity for each of the eight change areas for the reported quarter and the planned / expected level of maturity for the subsequent quarters in this year.

The maturity levels utilised are the ones described in the High Impact Changes Model (link below) and an explanation for each is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area
Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement
Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement
https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide further detail on the initiatives implemented and related actions that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter and any impact to highlight, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

Hospital Transfer Protocol (or the Red Bag Scheme):
The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.

Further information on the Red Bag / Hospital Transfer Protocol:
A quick guide is currently in draft format. Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. However, the AEDB lens is a more representative operational lens to reflect both health and social systems. Where there are wide variations in their maturity levels, making a conservative judgment is advised. Please note these observed wide variations in the narrative section on 'Challenges'.
Also, please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making this assessment, which could be useful in informing design considerations for subsequent reporting.

5. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

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

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4. High Impact Change Model

Selected Health and Well Being Board: Gateshead

		Maturity assessment				Narrative		
		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact
Chg 1	**Early discharge planning**	Mature	Mature	Mature	Mature	Regular reviews of the SAFER bundle to ensure it continues to be effectively implemented. Daily Board/Ward rounds include identification of patients with nearing EDD's in order that their	Patients who need to be repatriated or dischargd to other CCG/LA areas continue to be an issue and impact on flow.	Integrated working now takes place between community based and acute medical teams to ensure patients can continue on their journey/pathway of care, have a co-ordinated plan in place
Chg 2	**Systems to monitor patient flow**	Mature	Mature	Mature	Mature	Patient flow is monitored regularly (inc. EDD v actual discharge dates) using an electronic dasboard being trialled on ward 9 which displays live data at ward level to support proactive discharging.	Work will continue to optimise the discharge pathway.	Work has been undertaken with services/teams to develop more effective pathways/processes to access resources and support which cause bottlenecks.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Established	Established	Mature		Whilst good progress is being made in Gateshead, there is an inconsistent approach in other LA/CCG areas which impact on the flow of patients locally (casuing bed capacity issues).	An integrated service delivery model has been developed to support a MDT approach with joint assessment and discharge process.
Chg 4	**Home first/discharge to assess**	Plans in place	Plans in place	Plans in place	Plans in place		A review of the current Intermediate Care Service model is being undertaken to ensure that sufficient discharge management and alternative capacity is available.	Schemes have been established (funded through IBCF) which include a Bridging Service to enable patients to be discharged home without delys, whilst a 'Home First' pathway has been
Chg 5	**Seven-day service**	Plans in place	Plans in place	Plans in place	Plans in place		Challenges with sustaining capacity across certain parts of the system and interfaces between servcies	Specified support services are now available 7 days a week to ensure the next steps in the patients care pathway, as determined by the daily consultant led review are implemented. This includes a
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Established	Established		A model of trusted assessor has been developed between the Council and the Trust, which went live on 20.11.17. Initially ward based assessments will be coordindated by Discharge Liaison	An integrated single process has been developed locally so that no separate organisational sign off is necessary to ensure no delays in discharge.
Chg 7	**Focus on choice**	Mature	Mature	Mature	Mature	Choice protocol is in place and understood by staff, however this is under review (specifically to ensure standardisation with Regional Policy) Planning for discharge begins on	Whilst there has been much progress locally, there is an inconsistent approach by other CCGS/LA areas which impacts on local patient flows and bed capacity.	Local policy has been reviewed in collaboration with local stakeholders and patient representatives. Work has also been undertaken on the information provided to patients and families at the
Chg 8	**Enhancing health in care homes**	Mature	Mature	Mature	Mature	As a Care Home Vanguard Programme NHSE New Care Models team visited on December 6th and reported that they considered our programme complete given we have achieved all that we set	The challenge will be sustaining the front line clinical engagement and ensuring the momentum and focus of work continues in the post Vanguard world.	All metrics of Vanguard programme are being met with current quarter data revealing: lowest rate of hospital admissions for residents with urine infection for 2 years, reduction in oral

Hospital Transfer Protocol (or the Red Bag Scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q2 17/18	Q3 17/18 (Current)	Q4 17/18 (Planned)	Q1 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
UEC	**Red Bag scheme**	Plans in place	Mature	Mature	Mature		The challenge will be ensuring there is a robust evaluation of the introduction of the bags [reduced length of stay and staff experiences] and in ensuring there is an ongoing strategy for replacement	Transfer of care bags have been purchased for all residential and nursing care homes in Newcastle and Gateshead. A launch plan is in place and launch products have been developed.

Support needs
Adherence to the regional Repatriation policy by out of area providers.
None identified at this stage
Legal advice being sought regarding Choice policy
None identified at this stage
None identified at this stage
None identified at this stage
National Choice policy should be developed to ensure standardisation wherever a patient is being cared for.
Support to continue the journey so as to influence the lives of older people living with frailty wherever they might live (not just in care homes)is expected to come from the planned regional frailty plans.

Support needs
None anticipated.

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5. Narrative

Selected Health and Wellbeing Board: Gateshead

Remaining Characters:	17,730

Progress against local plan for integration of health and social care

At the heart of our vision and plan for integration is recognition that our Health and Social Care System requires new models of care delivery that enable collaboration across care settings, underpinned by sustainable, person centred co-ordinated care.
There are already well established system working arrangements across Gateshead – not only good interagency relationships at all levels of organisations, but also great examples of joint working and innovation which have been further enhanced through good multiagency working practices. However, despite this challenges remain around the fragility of the market which we recognise could impact on performance in Q3 and Q4.
The latest available performance data as outlined in the NEA, Res Admissions, Reablement and DTOCs metrics combined with cumulative data from Q2 return shows continued progress against targets for the year. However the impact of the forthcoming winter months will mean that maintaining these challenging trajectories will be difficult, despite rigorous and robust plans.
Care Home Vanguard performance has shown significant improvements not only in Gateshead but also in comparison to the other 5 care home vanguard sites. This continues to support the reduction in residential care.
Comparison Apr-Jul 16/17 to 17/18
15.2% reduction in residents conveyed to hospital following 999
reduction also seen in overall number of calls

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	18,088

Integration success story highlight over the past quarter

There have been a number of recent local successes and awards including the following:
The Local Authority Rapid Response Domiciliary care service won the 'The Putting People First/Personalisation Award' at the North East Care Awards on Thursday 30th November 2017. The award recognises a team who have embraced the 'Putting People First'/Personalisation agenda and can demonstrate an innovative approach to empowering people to have more control over the support they need in their lives. The judges were highly impressed with the 27 minutes average response time of the Rapid Response service with judges commenting that the service, in crisis situations "provides unique care to individuals and their circumstances while preventing admission to care or hospital. Their commitment and hard work is evident, well done".

Further success was gained at the awards when Lynne Shaw (Nurse Consultant) won the 'Good Nurse' award with the judges commenting of the excellent work of Lynne in "helping to transform services to improve the well-being of older people by improving the skills of staff". The judges stated "she truly is an outstanding nurse".

In addition, further success was gained in Audrey Nisbet (Shadon House) winning the 'Frontline Leaders' award, with the judges stating "Audrey is committed and passionate about working with people who have dementia and works to help rehabilitate people to go back to their own

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

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Checklist

[<< Link to Guidance tab]

Complete Template

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? If no please detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics

	Cell Reference	Checker
NEA Target performance	D7	Yes
Res Admissions Target performance	D8	Yes
Reablement Target performance	D9	Yes
DToC Target performance	D10	Yes
NEA Challenges	E7	Yes
Res Admissions Challenges	E8	Yes
Reablement Challenges	E9	Yes
DToC Challenges	E10	Yes
NEA Achievements	F7	Yes
Res Admissions Achievements	F8	Yes
Reablement Achievements	F9	Yes
DToC Achievements	F10	Yes
NEA Support Needs	G7	Yes
Res Admissions Support Needs	G8	Yes
Reablement Support Needs	G9	Yes
DToC Support Needs	G10	Yes

Sheet Complete:	Yes

4. HICM

	Cell Reference	Checker
Chg 1 - Early discharge planning Q3	F8	Yes
Chg 2 - Systems to monitor patient flow Q3	E9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3	F10	Yes
Chg 4 - Home first/discharge to assess Q3	F11	Yes
Chg 5 - Seven-day service Q3	F12	Yes
Chg 6 - Trusted assessors Q3	F13	Yes
Chg 7 - Focus on choice Q3	F14	Yes
Chg 8 - Enhancing health in care homes Q3	F15	Yes
UEC - Red Bag scheme Q3	F19	Yes
Chg 1 - Early discharge planning Q4 Plan	G8	Yes
Chg 2 - Systems to monitor patient flow Q4 Plan	G9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 Plan	G10	Yes
Chg 4 - Home first/discharge to assess Q4 Plan	G11	Yes
Chg 5 - Seven-day service Q4 Plan	G12	Yes
Chg 6 - Trusted assessors Q4 Plan	G13	Yes
Chg 7 - Focus on choice Q4 Plan	G14	Yes
Chg 8 - Enhancing health in care homes Q4 Plan	G15	Yes
Chg 1 - Early discharge planning Q1 18/19 Plan	H8	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19 Plan	H9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19 Plan	H10	Yes
Chg 4 - Home first/discharge to assess Q1 18/19 Plan	H11	Yes
Chg 5 - Seven-day service Q1 18/19 Plan	H12	Yes
Chg 6 - Trusted assessors Q1 18/19 Plan	H13	Yes
Chg 7 - Focus on choice Q1 18/19 Plan	H14	Yes
Chg 8 - Enhancing health in care homes Q1 18/19 Plan	H15	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I8	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams, if Mature or Exemplary please explain	I10	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I11	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I12	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I13	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I14	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I15	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I19	Yes
Chg 1 - Early discharge planning Challenges	J8	Yes
Chg 2 - Systems to monitor patient flow Challenges	J9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J10	Yes
Chg 4 - Home first/discharge to assess Challenges	J11	Yes
Chg 5 - Seven-day service Challenges	J12	Yes
Chg 6 - Trusted assessors Challenges	J13	Yes
Chg 7 - Focus on choice Challenges	J14	Yes
Chg 8 - Enhancing health in care homes Challenges	J15	Yes
UEC - Red Bag Scheme Challenges	J19	Yes
Chg 1 - Early discharge planning Additional achievements	K8	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K10	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K11	Yes
Chg 5 - Seven-day service Additional achievements	K12	Yes
Chg 6 - Trusted assessors Additional achievements	K13	Yes
Chg 7 - Focus on choice Additional achievements	K14	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K15	Yes
UEC - Red Bag Scheme Additional achievements	K19	Yes
Chg 1 - Early discharge planning Support needs	L8	Yes
Chg 2 - Systems to monitor patient flow Support needs	L9	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L10	Yes
Chg 4 - Home first/discharge to assess Support needs	L11	Yes
Chg 5 - Seven-day service Support needs	L12	Yes
Chg 6 - Trusted assessors Support needs	L13	Yes
Chg 7 - Focus on choice Support needs	L14	Yes
Chg 8 - Enhancing health in care homes Support needs	L15	Yes
UEC - Red Bag Scheme Support needs	L19	Yes

Sheet Complete:	Yes

5. Narrative

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes