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| **DECISION-MAKER:** | | **Joint Commissioning Board** | | |
| **SUBJECT:** | | **Better Care Highlight and End of Year Report** | | |
| **DATE OF DECISION:** | | **20 February 2019** | | |
| **REPORT OF:** | | **Director of Quality and Integration** | | |
| **CONTACT DETAILS** | | | | |
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| **STATEMENT OF CONFIDENTIALITY** | | |
| **NOT APPLICABLE** | | |
| **BRIEF SUMMARY** | | |
| This report provides an overview of performance and progress in 2019/20 against Southampton's Better Care programme and highlights the priorities for 2020/21. | | |
| **RECOMMENDATIONS:** | | |
| **1.** | **(i)** | To note 2019/20 performance against Southampton's Better Care programme and spend against the pooled budget, including the iBCF. |
| **2.** | **(ii)** | To note the priorities going forward for 2020/21. |
| **3.** | **(iii)** | To note the iBCF programme of spend for 2020/21. |
| **REASONS FOR REPORT RECOMMENDATIONS** | | |
| **4.** | The Joint Commissioning Board (JCB) is responsible for oversight of the Better Care pooled fund. This responsibility has been delegated to JCB from the Health and Wellbeing Board (HWBB). | |
| **5.** | National Better Care Fund Operating guidance was last published on 18 July 2019 for 2019/20. The Policy framework for 2020/21 is expected to be published in mid-late February. It is expected that 2020/21 will be a further transition year for the Better Care Fund with the potential for a 3 year plan for 2021/22 – 2023/24, subject to outcome of the Comprehensive Spending Review. It is also expected that the national conditions and metrics for 2020/21 will remain the same as they were for 2019/20. | |
| **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED** | | |
| **6.** | **NOT APPLICABLE** | |
| **DETAIL (Including consultation carried out)** | | |
| **7.** | **Overview**<br>Southampton's Better Care Plan aims to achieve the following vision:<br>• To put **individuals and families at the centre of their care and support**, meeting needs in a holistic way<br>• To provide the **right care and support, in the right place, at the right time**<br>• To make **optimum use of the health and care resources** available in the community<br>• To **intervene earlier** and build resilience in order to secure better outcomes by providing more coordinated, proactive services. | |

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| | • To **focus on prevention and early intervention** to support people to retain and regain their independence<br><br>It is a programme of whole system transformational change which is based around 3 key building blocks:<br><br>• **Implementing person centred, local, integrated health and social care**. This includes harnessing the assets within communities and the power of individuals in improving their own health and wellbeing. It also includes health, social care, housing and voluntary sector teams in each locality coming together to proactively identify those people most in need in the local area and plan and deliver care and support in a more joined up and personalised way.<br><br>• **Joining up Rehabilitation and Reablement, hospital discharge teams and other city wide services into integrated health and social care teams** that in turn link with each locality.<br><br>• **Building capacity** across the system to promote and support people to maintain their independence for as long as possible. This includes promoting self management approaches and supporting the role of carers. It also includes developing the capacity of the voluntary and community sector to meet lower level needs in local communities, as well as investing in the home care sector to enable more people to continue living in their own homes. |
| **8.** | During 2019/20, Southampton's Better Care programme has been refreshed to align with the city's new **5 Year Health and Care Strategy (2020 – 2025)** which in turn aligns to the Council Strategy, CCG operating plan, NHS Long Term Plan and Sustainability and Transformation Partnership/Integrated Care System plans and is a subset of the wider 10 year strategy for health and wellbeing led by the Health and Wellbeing Board.<br><br>The 5 Year Health and Care Strategy sets out the following goals to be achieved across the full life course (Start Well, Live Well, Age Well, Die Well):<br><br>• Reducing inequalities and confronting deprivation<br>• Tackling the city's biggest killers : Cancer, Circulatory diseases and Respiratory diseases<br>• Improving earlier help, care and support<br>• Improving mental and emotional wellbeing<br>• Working with people to build resilient communities and live independently<br>• Improving joined up, whole person care |

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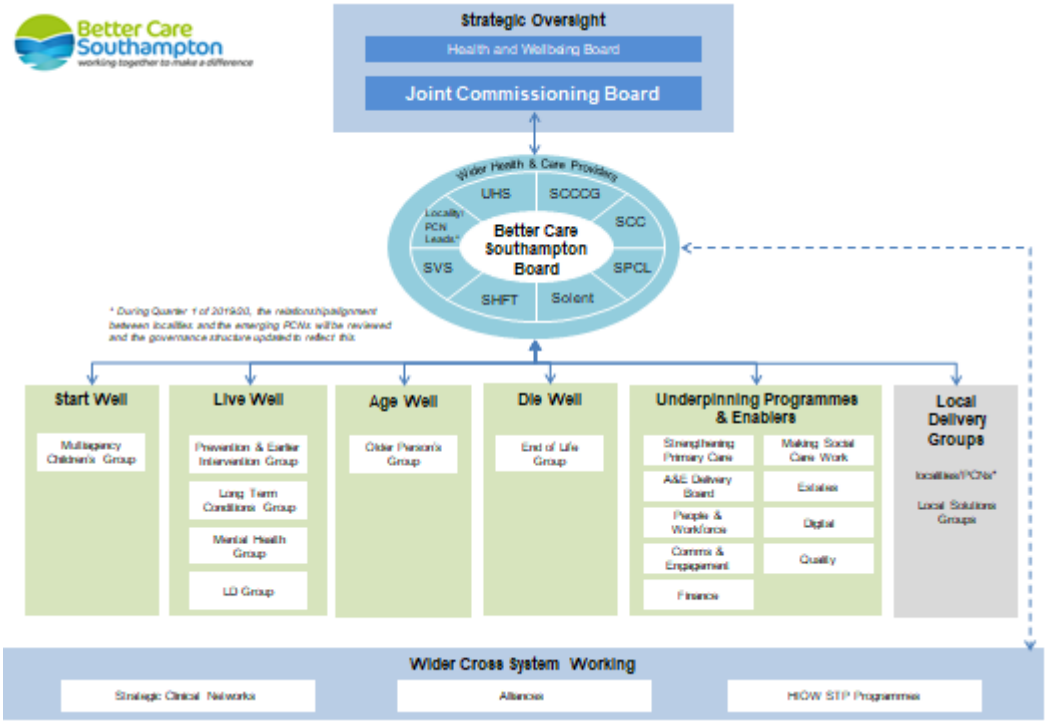
| **9.** | Better Care is seen as central to delivery of the 5 year strategy and the Better Care governance structure (as shown below) has been updated to reflect the core elements.<br>  <br><br>Membership of the Better Care Southampton Board includes the CCG, the GP Federation (Southampton Primary Care Ltd), the Council (Director of Adult Social Care), the acute Trust (University Hospital Southampton), the community Trust (Solent NHS Trust), the mental health and learning disability community provider (Southern Health), the Voluntary and Community Sector (Southampton Voluntary Services), the clinical leads from each of the 3 Better Care localities and the Clinical Directors from each of the 6 PCNs. The Board reports to the Health and Wellbeing Board.<br>Reporting into the Better Care Southampton board there are working groups for each of the work programmes in the 5 Year Health and Care Plan. The working groups report into the Better Care Board on a thrice yearly basis highlighting progress and any issues for escalation.<br>The locality structure on which our Better Care model is based enables needs and gaps to be analysed at a very local level and specific plans to be developed in response. We have specifically invested in locality leadership teams for this purpose which comprise dedicated input from professional leads, including Primary Care Networks (PCNs), social care and the two community trusts (Solent and Southern Health). We have also invested in data analyst time to develop detailed information packs on health and care need and resource utilisation at a locality level. |
| **10.** | The **Better Care Fund** pools resources from both the CCG and Local Authority to support the delivery of the Better Care Programme. In 2019/20 this totals approx. £126.50M (approx £79.00M from the CCG and £47.00M from the Council, making Southampton one of the country's top ten authorities for pooling an amount way beyond its national requirement which is £16.177M, demonstrating its commitment to integrating health and social care at scale.<br>Southampton's Better Care Fund is made up of the following schemes:<br>1. Supporting Carers<br>2. Integrated locality teams<br>3. Integrated Rehabilitation and Reablement and Hospital Discharge<br>4. Aids to Independence<br>5. Prevention and Early Intervention |

6. Adult Learning Disability Joint Commissioning
7. Promoting uptake of Direct Payments
8. Transforming Long Term Care
9. Integrated provision for children with SEND
10. Integrated health and social care provision for children with complex behavioural & emotional needs

**11. Performance as at Q3 2019/20**

The table below provides a summary of performance against the key Better Care national indicators. Owing to monthly reporting timescales, it is only possible to provide activity data up to Month 8, i.e. 30 November 2019.

| Metric | YTD Performance versus Plan | YTD Performance versus last year | Comments |
|---|---|---|---|
| **NEL Admissions** | 5% above plan (21,258 versus 20,272) | 6% above last year (21,258 versus 20,142) | There has been an increase in NEL admissions this year compared to last year. The majority of this increase has been in very short stay admissions (0 day admissions have increased by 9% whilst admissions of more than one day have increased by 4%). There has been significant growth in ED attendances (12% compared to last year)<br>When considering the different age ranges, the increase in admissions is similar for both working age adults and older people. The reduction in child admissions is purely as a result in changes to the pathway and coding of activity. |
| - **Children**<br>- **Working Age Adults**<br>- **Older People** | | 7% lower<br>7% higher<br>8% higher | |
| **DTOC** | Rate of Lost bed days as % of overall bed availability:<br>6.6% as at Nov 19compared to 3.5% target<br>YTD average is 5.6%<br>Average daily number of delays:<br>45.5 for Nov 2019 against target of 26.7 (70% over target)<br>YTD average = 38.1 average daily delays | Rate of Lost bed days as % of overall bed availability:<br>6.6% compared to 5.5% Nov 2018<br>YTD average is 5.6% compared to 6% for Apr – Nov 2018<br>Average daily number of delays:<br>45.5 for Nov 2019 compared to 37.3 for Nov 2018<br>YTD average = 38.1 average daily delays compared to 40.9 last year | The DTOC rate has been increasing since April<br>As at Nov 2019, DTOC rate at an individual Trust level was:<br>• UHS: 6.5% in Nov 19 vs 7% in Nov 18 and 5.5% for YTD vs 6.8% last year<br>• Solent: 4.6% in Nov 19 vs 3.5% in Nov 18 and 3.2% for YTD vs 2.8% last year<br>• Southern Health: 11.1% in Nov 19 vs 4.9% in Nov 18 and 8.9% YTD vs 3.7% last year<br>Further detail on DTOC can be found at Appendix 1. |
| **Permanent Admissions to residential homes** | 8% above plan (186 admissions versus 173) | 6% lower than last year (186 admissions versus 198) | Whilst we are not on track to achieve the reduction we planned for this year, permanent admissions are 6% lower than this time last year. |

**12. Performance Commentary**

- **Permanent admissions to residential and nursing homes:** We have seen a steady reduction in rates of admission to residential and nursing homes for people over 65 since 2015/16. Particular action to reduce residential and nursing home admissions has included:

- Continued expansion of Extra Care housing to provide an alternative to residential admission, supporting people to stay independent for longer. We are currently preparing for the opening of Potters Court in 2020 which will offer 80 additional units of Extra Care.
- Development of community activities and support including the roll out of the Community Solutions Service (So:Linked). The service seeks to promote an approach for the city which results in an increase in the breadth and depth of community based activity available and being accessed, that supports people to live well and independently in the community, promotes self-help and a culture where people help others in their community. The new Community Solutions Service also includes community navigators to help people identify and access the help they might need. In addition the ongoing development of Southampton Living Well Service offering day time activity and care.
- Implementation of the falls prevention strategy, acknowledging that falls (particularly when they result in a hospital admission) are a major cause of loss of confidence and independence which can lead to residential admission. During 2019/20 we have re-procured the Falls exercise offer; piloted a scheme which enables health professionals to refer people at risk of falls to the City's Telecare Service where they can receive equipment to detect a fall and a fast response to prevent a long lie; and increased capacity in our Community Independence Service to provide assessment and support for those who have suffered a fall. We are currently in the process of evaluating all these schemes.
- Ongoing work to assess and provide support to carers, enabling them to care for longer. The ICU commissions a Carers in Southampton service that delivers universal identification, advice and support as well as delegated carer assessments. Engagement with carers has grown significantly with numbers contacting the service increasing from 200 in 2014/15 to 2,712 by the end of Q3 2019/20. The numbers accessing information via the website has increased from 990 in 2014/15 to 75,906. The number of carers reached during 2018 to Q3 of 20/19/20 is 118,111.

- **Delayed transfers of care (DTOC)**: Whilst our DTOC rate has been reducing over the last 2 years, DTOC still remains significantly above where it should be, above our comparator authorities, the main pressures being at UHS, but also Southern Health. When reviewing the main reasons for delay, home care placement is the most prominent followed by awaiting assessment (which relates to social care providers coming into hospital to assess), nursing home placement and then awaiting further non acute NHS care. Delays particularly increase at the weekend. Further analysis of these delays shows that the main reasons are associated with increasing levels of complexity requiring more "double up" care or harder to source nursing home placements. **A detailed report on our DTOC position and the action being taken to address it can be found at Appendix 1**.
- **Non Elective (NEL) admissions:** Since November 2018, an increased volume of A&E attendances has led to an increased number of non elective admissions. This step-change has been seen across the country and is not specific to Southampton. The majority of the increase has been in short stay admissions (less than one day), with the most notable increase being in the elderly population. Changes to the A&E pathway, such as the introduction of the Frailty Unit/Same Day Emergency Care (SDEC) which are coded as NEL admission could be artificially contributing to some of this increase. Our overall plan for 2019/20 was to hold NEL admissions at 2018/19 levels and prevent any further growth, by implementing a number of initiatives to reduce urgent care activity. Working with Hampshire (West Hampshire CCG and Hampshire County Council), Southampton has developed a Whole System Urgent & Emergency Care Recovery Plan. Particular actions which Southampton is taking forward jointly with Hampshire include:
  - Targeted choose well campaign focused on geographical areas with high A&E attendances which could be managed in the community.
  - Ensuring newly commissioned models within the Extended Access Hubs and Urgent

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| | Treatment Centres are fully embedded and utilised to reduce attendances at A&E for minor illnesses and injury<br>o Identifying the top 200 high intensity users (HIU) presenting to A&E and ensuring there are individual care plans in place for each<br>o Implementation of urgent community response services at the Same Day Emergency Care (SDEC) Service for those aged over 80 at UHS with the aim to optimise same day or next day turnaround of appropriate patients, including establishing a same day transport facility to ensure timely and safe transfer home with support from the voluntary sector. As a result, SDEC is seeing and discharging more people on the same day (the same day discharge rate increasing from approx. 15% to 30%)<br>o Introduction of a clinician from the Urgent Response Service into the South Central Ambulance Service call centre with knowledge of the local pathways and services in order to support the call handlers with identifying alternatives to hospital. This scheme is currently being evaluated but early data is showing that it is having success in reducing hospital conveyance and subsequently admission (of 53 patients over a 4 month period, 43 went on to have no hospital admission).<br>o Roll out of the Enhanced Health in Care Homes service to all residential homes across the city and consideration of additional support to be provided to nursing homes – this has resulted in a further 6% reduction this year in hospital admissions from these homes.<br>o Improvements to mental health crisis care - working in partnership with Southern Health and Solent Mind to develop "The Lighthouse" a new community based facility that will support individuals in a recovery-focused way to manage their mental health crisis. Local residents using the facility receive interventions in a therapeutic environment, with the facility being staffed by mental health nurses, as well as peer supporters provided by Solent Mind who bring their lived experience to the service. In addition, we have secured NHS transformation funding to increase the capacity of the Crisis Resolution Home Treatment Team to allow more home treatment to be provided, giving people a real alternative to a hospital admission.<br>o Mental health support in NHS 111 – working with other commissioners, South Central Ambulance Service and Southern Health, we have secured NHS transformation funding to expand the current 'alternative to crisis' service with the introduction of an open access urgent referral. This means that if someone calls 111 with a mental health concern, they will be directed to specialist mental health nurses who can provide specialist support.<br>o Alcohol InReach service. We have been working with our hospital specialist alcohol nurse service, the Alcohol Care Team (ACT-UHS) and our community drug and alcohol support service, Change, Grow, Live (CGL Southampton) to increase the capacity of ACT-UHS and further develop the InReach programme to support people identified with an alcohol concern into treatment. This means that more people will have access to our specialised alcohol support to help reduce alcohol related harm. |
| **13.** | **Key Developments during 2019/20**<br>Below is a brief summary of some of the key developments in 2019/20 against each of the Better Care programme priorities.<br>• **Priority 1: Integrated care based around localities and Primary Care Networks (PCNs)**<br>➢ During 2019/20 the leadership teams in each of the 3 localities have been strengthened with dedicated time from clinicians, operational management from Southern Health and Solent and professionals in Adult Social Care to review the needs of the locality and develop priorities for improving outcomes.<br>• **Priority 2: A much stronger focus on prevention and early intervention**<br>➢ Continued development of the Southampton Living Well Service which commenced in |

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| | April 2018 and is transforming the way we provide older people's day care into a more person centred, community focussed model. The provider of this service is co-producing an activity offer with service users and will establish an affiliate scheme with local activity groups/organisations which will significantly increase the number and range of activities being offered outside of the traditional day care setting.<br>➢ Re-procurement of the Falls Exercise offer which is now operating across the whole city<br>➢ Further development of the Welcome Home scheme which is now in its second year and is a volunteer based programme which supports people following discharge to get back on their feet and regain their independence. 95 requests for help have been received to date, 83 (88%) of which received support. 61 (64%) received support in their homes and 22 (23%) received telephone support only. Since January 2019 the number of volunteers ("Communiteers") available to help with Hospital Homecoming requests has increased from 28 to 47<br>• **Priority 3: A shift in the balance of care away from bed based provisions and into the community**<br>➢ Continued development of the integrated rehabilitation and reablement service to support more people in the community, in their own homes.<br>➢ Development of a pathway in rehab and reablement for delivering community based intravenous medication, enabling patients with higher levels of acuity to be supported outside hospital.<br>➢ Sensory services have been restructured resulting in a significant reduction in the waiting list and a move from reactive to proactive care in the community, with sensory services being seen as everyone's business.<br>➢ Home care procurement. Commissioners have worked with providers to develop a new model for Home Care delivery in Southampton. The procurement process was completed early 2019 and the new Framework started on 1 April 2019. The framework includes a new role of Lead provider which makes it possible for agencies to be involved in system wide work and has already made possible a reduction in the waits experienced for a care package from referral to start date.<br>• **Priority 4: Significant growth in the community and voluntary sector**<br>➢ Procurement of the So:Linked Service as referenced above has led to a new Community Navigation and Community Development service. This service was procured in 2018/19 and started in October of 2019. The service seeks to promote an approach for the city which results in an increase in the breadth and depth of community based activity available, and being accessed, that supports people to live well and independently in the community, promotes self-help and a culture where people help others in their community.<br>• **Priority 5: Develop new models of care**<br>➢ Continued development of an integrated team for adults with learning disabilities, which brings together Council, Southern Health and CCG staff under a single management structure.<br>➢ The Improving Access to Psychological Therapies (IAPT) Steps to Wellbeing Service has continued to develop integrated physical and mental health pathways adding Atypical Respiratory Disease, Chronic Pain and Persistent Physical Symptoms for people experiencing low mood/depression, anxiety, stress or other common mental health problems to the pathways previously developed for Diabetes and Chronic Obstructive Pulmonary Disease (COPD). |
| **14.** | **Priorities for the Better Care Programme going forward**<br>Moving forward, Better Care will be central to the delivery of the 5 Year Health and Care Strategy by developing the new models of place based person centred integrated care which will form the foundations for implementing the Strategy's priorities. Key Better Care priorities for 2020/21 will be: |

- Development of **integrated care teams** across health and social care, physical and mental health in each of the localities, aligning with Primary Care Networks.
- Focused work to reduce **DTOC** with a critical review of the city's implementation of the High Impact Change Model for Hospital Discharge and operation of each of the 3 discharge pathways
- Fully embedding the **Enhanced Health in Care Homes** model with roll out to Nursing Homes and in future the city's Extra Care schemes
- Further expansion of **Extra Care Housing** with the development of 80 new bed spaces at Potters Court which will open in 2020 at the same time as reviewing the need for further developments in the East and Centre of the city
- Continued development of responsive **Mental health** services
- Implementation of **Southampton's Frailty model**, to manage higher levels of acuity in the community, e.g. intravenous medication and strengthen multidisciplinary working at the hospital front door to ensure that people are directed in a timely way to the best setting for supporting their needs, wherever possible in their own homes
- Working with the new So:Linked Service to continue to build capacity within the **community and voluntary sector** to provide earlier more preventative support, including taking forward development of a place based giving scheme
- Development of an integrated **community transport** model to enable people to better access support and activities across the city
- Taking forward opportunities for **integrating equipment, aids, care technology and home adaptation services** to provide more person centred support as well as maximizing the use of the DFG to better support people's independence

**RESOURCE IMPLICATIONS**

**Revenue**

**15.** Financial performance against each Scheme is monitored on a monthly basis by the Better Care Finance and Performance Group.

The total value of the pooled fund for 2019/20 (including the iBCF and DFG) is approx. £126.50M (approx £79.00M from the CCG and £47.00M from the Council).

As at Month 9, overall performance against the pooled fund was a projected year end under-spend of £0.31M, which represents a percentage variance against budget of 0.24%. This is made up of a £0.10M under-spend for the CCG and a £0.20M under-spend for the Council.

The main areas of under-spend contributing to this position are the Prevention and Early Intervention scheme (where there is an under-spend of £0.13M relating partly to planned contract savings and partly to vacancies) and Rehabilitation and Reablement (where there is an under-spend of £0.24M which relates to vacancies that the service has not been able to recruit to).

**16.** The value of the BCF pooled fund for 2020/21 is expected to be a roll-over of the funds from 2019/20 with inflation, growth and investment added to the NHS contribution in line with local agreement and Operational Planning Guidance (details still to be finalised).

**17.** The iBCF is part of the BCF pooled fund and comprises two tranches as follows:

| | **Improved Better Care Fund (Tranche 1)** | **Additional Improved Better Care Fund (Tranche 2)** | Total Improved Better Care Fund |
|---|---|---|---|
| 2019/20 Grant | £7,713,111 | £1,567,547 | £9,280,658 |

The first tranche is allocated directly to Adult Social Care and used for care packages and placements. This tranche has been increasing year on year.

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| | The second tranche is used for service transformation and time-limited projects linked to Better Care priorities (e.g. integration of services, prevention and early intervention, supporting independence and reducing reliance on bed based care, reducing DTOC). This tranche has been reducing year on year.<br><br>During 2019/20 the total value of the second tranche of IBCF is £2.67m, which includes a carry forward from 2018/19 of £1.1m. A summary of how this has been allocated is included in Appendix 2. |
| **18.** | For 2020/21, both tranches of the iBCF will be a roll over from 2019/20. A summary of the 2020/21 plan for using the second tranche IBCF, including the carry forward of £0.33m, is also included in Appendix 2. |
| **Capital** | |
| **19.** | There is a £3.6M carry forward against the DFG grant that has built up over the years as a result of top up grants received at the end of each year. Use of this funding is being considered as part of a review of the DFG which is being taken forward by the Integrated Commissioning Unit and will be presented as a separate report to the Joint Commissioning Board. |
| **Property/Other** | |
| **20.** | There are no specific property implications arising from the Better Care pooled fund. However as part of the 5 Year Health and Care Strategy there is an enabling workstream specifically looking at the use of our collective estate across the Council, the CCG, primary care and NHS providers with a view to supporting the further development of integrated working. |
| **LEGAL IMPLICATIONS** | |
| **Statutory power to undertake proposals in the report:** | |
| **21**. | The legal framework for the Better Care Pooled Fund derives from the amended NHS Act 2006, which requires that in each Local Authority area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2017-19, NHS England set the following conditions:<br>• Agreement of a joint plan between the CCG and Local Authority<br>• NHS contribution to social care is maintained in line with inflation<br>• Agreement to invest in NHS-commissioned out-of-hospital services<br>• Implementation of the High Impact Change Model for Managing Transfers of Care.<br><br>Southampton is compliant with all four of these conditions. |
| **Other Legal Implications:** | |
| **22.** | None |
| **CONFLICT OF INTEREST IMPLICATIOINS** | |
| **23.** | None |
| **RISK MANAGEMENT IMPLICATIONS** | |
| **24.** | Risks on specific Better Care Fund Schemes are monitored on a monthly basis. Key risks and issues for the Better Care Programme overall are summarised below:<br>• **Capacity of the care market** to meet increasing needs and support additional schemes to improve discharge - To mitigate this, the ICU is working proactively with the care market and utilising alternative mechanisms such as retainers and block contracts to provide increased stability.<br>• **Resilience in the voluntary sector** and ability to respond to new ways of working - A number of mitigating actions are being taken including: various procurement options being considered |

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| | to make best use of local market and encourage innovation; support to local agencies also being considered as part of the developments; proactive review of any bidding opportunities. |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| **25.** | Southampton's Better Care Programme supports the delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live safe, healthy and independent lives" and "Children get a good start in life") and CCG Operating Plan 2017-19, which in turn complement the delivery of the local HIOW Sustainability and Transformation Partnership, NHS 5 Year Forward View, Care Act 2014 and Local System Plan. |
| **26.** | Southampton's Better Care Plan also supports the delivery of Southampton's Health and Wellbeing Strategy 2017 - 2025 which sets out the following 4 priorities:<br>• People in Southampton live active, safe and independent lives and manage their own health and wellbeing<br>• Inequalities in health outcomes and access to health and care services are reduced.<br>• Southampton is a healthy place to live and work with strong, active communities<br>• People in Southampton have improved health experiences as a result of high quality, integrated services |

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| **KEY DECISION?** | **Not Applicable - No decision required** |
| **WARDS/COMMUNITIES AFFECTED:** | **All** |
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| SUPPORTING DOCUMENTATION | |
| **Appendices** | |
| 1. | Delayed Transfers of Care Report |
| 2. | IBCF Expenditure |

**Documents In Members' Rooms**

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| **1.** | **None** |
| **Equality Impact Assessment** | |
| **Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.** | **No - Update only** |
| **Privacy Impact Assessment** | |
| **Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.** | **No - update only** |
| **Other Background Documents**<br>**Other Background documents available for inspection at:** | |

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| **Title of Background Paper(s)** | | **Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)** |
| **1.** | **None** | |