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Blackpool Council

12 April 2016

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 20 April 2016 at 3.00 pm
At the Solaris Centre, New South Promenade

A G E N D A

1 DECLARATIONS OF INTEREST

Members are asked to declare any interests in the items under consideration and in doing so state:

(1) the type of interest concerned; and

(2) the nature of the interest concerned

If any member requires advice on declarations of interests, they are advised to contact the Head of Democratic Governance in advance of the meeting.

2 MINUTES OF THE LAST MEETING HELD ON 2 MARCH 2016 (Pages 1 - 6)

To agree the minutes of the last meeting held on 2 March 2016 as a true and correct record.

3 STRATEGIC COMMISSIONING GROUP (SCG) UPDATE (Pages 7 - 18)

To update the Board on the activity of the Strategic Commissioning Group since the last meeting.

4 TRANSFORMING CARE UPDATE (Pages 19 - 126)

To update the Health and Wellbeing Board on progress of the Transforming Care programme.

5 BETTER CARE FUND (Pages 127 - 172)

To update the Board on the Better Care Fund. To seek approval in principle for the Better Care Fund 2016/17 and to agree arrangements for ongoing monitoring and governance.

6 HEALTH AND WELLBEING STRATEGY (Pages 173 - 206)

To inform the Board of progress made to develop the Health and Wellbeing Strategy 2016 – 19 and invite discussion on the draft content.

7 HEALTHIER LANCASHIRE (Pages 207 - 220)

To ensure that the organisations on the Health and Wellbeing Board are aware of the establishment of the Joint Committee of Clinical Commissioning Groups (JCCCG) and their role in it or in relation to it.

Briefly to confirm with the Board the arrangements for developing a Sustainability and Transformation Plan on a Lancashire and South Cumbria footprint, to assure the Board that this is aligned to the development of Healthier Lancashire.

8 FORWARD PLAN (Pages 221 - 226)

To inform the Health and Wellbeing Board members of the draft Forward Plan that has been developed for the Board.

Venue information:

First floor meeting room (lift available), accessible toilets (ground floor), no-smoking building.

Other information:

For queries regarding this agenda please contact Lennox Beattie , Executive and Regulatory Manager , Tel: 01253 477157, e-mail Lennox.beattie@blackpool.gov.uk

Copies of agendas and minutes of Council and committee meetings are available on the Council's website at www.blackpool.gov.uk.

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 2 MARCH 2016

Present:

Councillor Cain, Cabinet Secretary (Resilient Communities), Blackpool Council (in the Chair)
Councillor Clapham, Opposition Group Member
Councillor D Coleman, Cabinet Assistant (Resilient Communities)
Councillor Collett, Cabinet Member for Children's Services and Reducing Health Inequalities

David Bonson, Chief Executive Officer, Blackpool Clinical Commissioning Group
Delyth Curtis, Director of People, Blackpool Council
Dr Amanda Doyle, Chief Clinical Officer, Blackpool Clinical Commissioning Group
Roy Fisher, Chairman, Blackpool Clinical Commissioning Group
Dr Arif Rajpura, Director of Public Health, Blackpool Council
Karen Smith, Deputy Director of People- Blackpool Council

In Attendance:

Lennox Beattie, Executive and Regulatory Support Manager, Blackpool Council
Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council
Nicky Dennison, Senior Public Health Practitioner, Blackpool Council
Lynn Donkin, Public Health Specialist, Blackpool Council
Superintendent Nikki Evans, Lancashire Constabulary
Dr Mark Johnston, Deputy Chief Operating Officer, Blackpool Clinical Commissioning Group
Judith Mills, Public Health Specialist, Blackpool Council
Paul Greenwood, Interim Chief Executive, Blackpool Council for Voluntary Services
Helen Lammond-Smith, Head of Commissioning, Blackpool Clinical Commissioning Group
Carmel McKeogh, Deputy Chief Executive, Blackpool Council
Liz Petch, Public Health Specialist, Blackpool Council
Wendy Swift, Chief Executive Blackpool Teaching Hospitals NHS Foundation Trust
Justin Nield and Glyn Smithson, Fulfilling Lives

Apologies:

Gary Doherty, Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust
Jane Higgs, NHS England
Ian Johnson, Chairman, Blackpool Teaching Hospitals NHS Foundation Trust
Dr Leanne Rudnick, GP Member, Blackpool Clinical Commissioning Group

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 27 JANUARY 2016

The Board considered the minutes of its last meeting.

Resolved:

That the minutes of the last meeting held on the 27 January 2016 be approved and signed by the Chairman as a correct record.

3 STRATEGIC COMMISSIONING GROUP UPDATE

The Board received an update from the Strategic Commissioning Group presented by Mrs Delyth Curtis, Director of People.

Mrs Curtis presented the finalised minutes of the meeting held on the 16 December 2015 on which a verbal presentation had been given at the last meeting. It was noted that this meeting included a presentation on Fulfilling Lives and a similar presentation had been included on the agenda for the meeting of the Board. Mrs Curtis also explained that the Group had been unable to support the application for funding from the Council for Voluntary Services at this meeting but would be writing separately to the organisation with details of support in kind that partners could offer.

Mrs Curtis then presented a brief update on the meeting of the Strategic Commissioning Group held on the 24th February 2016. She highlighted that the key items on the meeting's agenda had been the Healthier Lancashire Programme and the Better Care Fund and that these items would form part of the agenda for the Board meeting on the 20th April 2016. It was noted that the minutes from the 24 February 2016 meeting of the group would be presented

Resolved:

1. To note the minutes from the Strategic Commissioning Group meeting on 16 December 2015, as attached at Appendix 5a to the agenda.

2. To note the verbal update from the meeting on the 24 February 2016.

3. To note that the minutes from the meetings on the 20 January 2016(on which a verbal update was given at the last meeting) and from the 24 February 2016 will be brought to the next Board meeting in April.

4 HEALTH PROTECTION FORUM UPDATE

The Board received an update on the work of the Health Protection Forum from Mrs Donna Taylor (Lead Public Health Nurse, Blackpool Council). She reminded members that the Health Protection Forum had been created by the Health and Wellbeing Board to provide a mechanism for warning and informing on local health protection arrangements within Blackpool. The report was the first of six-monthly reports of the Health Protection Forum.

Mrs Taylor highlighted the issues considered by the Health Protection Forum as outlined at Paragraph 5.2 of the report namely: the new structure for the Cumbria and Lancashire Health Protection Team, Seasonal Flu Vaccination Uptake rates, the Forum's recommendation that recommendation that Blackpool Clinical Commissioning Group tests their emergency planning and resilience and response planning arrangements, Food Standards and Allergy Issues and Food Control enforcement. The Board particularly noted the uptake of Seasonal Flu vaccination and the Board members expressed concerns regarding low uptake rates in some risk groups and among Council employees. Board members also noted the pending prosecution of a business regarding the undeclared presence of allergens.

Resolved:

1. To receive the Health Protection Report for the period 1 April 2015 to 31 January 2016 as attached at Appendix 4a, to the agenda.

2. To note the issues outlined at Paragraph 5.2 of the Health Protection report and agree that no further action is necessary.

5 DRUG STRATEGY

The Board received a presentation from Mrs Nicky Dennison (Senior Public Health Practitioner, Blackpool Council) on the development of a refreshed Drug Strategy.

Mrs Dennison explained that it was intended the Drug Strategy was the first to be created by the Council and other partners that included a whole system approach to the issue of drug use in contrast to previous strategies which concentrated on treatment plans for problematic opiate and crack cocaine users.

The intention with the new Drug Strategy was to deal with the full range of issues acknowledging that problem drug use often linked to a range of other factors including mental health, alcohol misuse, homelessness and crime, and was therefore a key part of overall health and wellbeing.

Mrs Dennison highlighted the proposed key objectives of the strategy: Prevent harm to individuals, Build recovery, Preventing harm to the community, Empowering young people to make informed choices, Keeping children safe and rebuild families and Building community and increasing engagement and inclusiveness in Blackpool.

The Board discussed the principles of the proposed drug strategy and endorsed these principles but considered that it was essential to also prioritise the areas with the greatest chance of success. The Board emphasised that given the impact on young people of drug use that linkages should be developed with the HeadStart and Betterstart programmes. The Board also considered community rehabilitation and meaningful activities, such as the Fulfilling Lives programme dealt with separately on the agenda, as a key way to aid recovery.

Resolved:

1. To agree to support the development the Drug Strategy.

2. To agree the principles of the Drug Strategy outlined in the report at Paragraph 5.7 and presentation.

3. To agree that the Strategic Commissioning Group consider further how partners can work together on the delivery of the strategy in light of substance misuse being one of the Board's four priorities and align this with the Health and Wellbeing Strategy to maintain consistency and ensure a joined up approach.

6 FULFILLING LIVES

The Board received a presentation on the Fulfilling Lives project from Glyn Smithson and Justin Nield from the programme.

They outlined that Fulfilling Lives was a lottery funded project, with Blackpool being chosen as one of twelve areas selected by the Big Lottery Fund. The key aim of project was deal with people whose chaotic lifestyles inflicted harm on themselves and large costs on emergency services. The project was about creating pathways to help these people make a positive contribution to local communities and change systems to better deal with these people in the future. The project was set up for people involved in the criminal justice system, with drug and alcohol misuse and homelessness by dealing the range of problems that they were experiencing in totality. Mr Nield gave a number of case studies regarding how the service helped people and that often by finding for example a house, a meaningful activity or a job then this provided motivation for dealing with their other problems.

Mr Smithson explained that a major success for Fulfilling Lives in Blackpool involvement of ex-service users (people who previously had chaotic lifestyles caused by problems with alcohol, drugs, offending behaviour, homelessness and mental health issues) in the design and delivery of this programme.

The Board endorsed the Fulfilling Lives model but agreed that it would useful to receive a further update in the future.

Resolved:

1. To note the Fulfilling lives project and promote the partnership working across Blackpool.

2. To agree that the project plays a key role in future commissioning of services for people with complex needs including the drug strategy.

3. To receive a future update on the progress of the Fulfilling Lives programme.

7 MENTAL HEALTH SERVICES PRESENTATION

The Board received a presentation on issues related to mental health services from Helen Lammond-Smith, Blackpool Clinical Commissioning Group.

Ms Lammond-Smith outlined the significant challenges for Blackpool, considering that Blackpool had the 5th highest rate for all mental health conditions.

She outlined the provision available in Blackpool through the Harbour in patient provision.

Ms Lammond-Smith outlined the waiting list initiative by Blackpool Clinical Commissioning Group to reduce waiting times for Improving Access to Psychological Services programme. She outlined the target of 75% of people seen within 6 weeks of referral and 95% of people seen within 18 weeks of referral. The Board noted that Blackpool Teaching Hospitals Trust had reported that at January 2016, 80% of patients have been seen within 6 weeks and 98% seen within 18 weeks. In noting this achievement, the Board expressed the view that steps should be taken to ensure that this performance continued into the future.

Ms Lammond-Smith outlined her view that there were significant advantages in addressing issues in organized ways of joint working such as through the Blackpool Mental Health Alliance approach to dealing with community mental health.

The Board in noting the complex issues around mental health provision agreed that the issue should be one to be dealt with by the Healthier Lancashire plan.

Resolved:

To note the presentation and refer the issue for further consideration by the Healthier Lancashire Board.

8 FORWARD PLAN

The Board considered the draft forward plan for forthcoming agendas, which would enable the Board to strategically plan its future agendas and ensure that items were relevant to the Board's priorities. It was noted that the Board had agreed under Minute Item 6 to receive a further update on the work of the Fulfilling Lives programme.

Resolved:

1. To approve the Health and Wellbeing Board Forward Plan as set out in Appendix 8a to the agenda.

2. To add a further update on the work of the Fulfilling Lives programme to Forward Plan.

9 DATE OF NEXT MEETING

The Board noted the date of the next meeting as the 20 April 2016.

Chairman

(The meeting ended 5.10 pm)

Any queries regarding these minutes, please contact:
Lennox Beattie Executive and Regulatory Manager
Tel: 01253 477157
E-mail: lennox.beattie@blackpool.gov.uk

Report to:	**Health and Wellbeing Board**
Relevant Officer:	David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	20 April 2016

STRATEGIC COMMISSIONING GROUP (SCG) UPDATE

1.0 Purpose of the report:

1.1 To update the Board on the activity of the Strategic Commissioning Group since the last meeting.

2.0 Recommendation(s):

2.1 To note the minutes from the Strategic Commissioning Group meetings on 20 January 2016 and 24 February 2016, which have been presented verbally at previous meetings of the Board.

2.2 To receive a verbal update from the meeting on 16 March 2016 and to note that the minutes of this meeting will be brought to the next Board.

2.3 To note the main actions arising from the work of the group.

3.0 Reasons for recommendation(s):

3.1 The Strategic Commissioning Group is a sub-group of the Board, which is responsible for overseeing the integration and alignment of commissioning across the Clinical Commissioning Group and the Council. It has a duty to update the Board on activity against its work programme and future planned activity.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

No alternative options

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increasing resilience."

5.0 Background Information

5.1 The minutes from the January and February meetings are attached at Appendix 3a and 3b. Items included:

- A presentation from Council for Voluntary Services regarding a request for infrastructure funding
- An update on the Intermediate Care Commissioning Review
- A demonstration of the new Joint Strategic Needs website
- A report on the Better Care Fund submission for 2016/17
- An update and discussion on the Healthier Lancashire programme
- A discussion on the NHS Sustainability and Transformation Plans
- An update on New Models of Care

5.2 The meeting in March covered the following items; minutes of this meeting is not yet available therefore a verbal update will be given of any decisions that were made.

- An update on progress to integrate some health services into Children's Centres; the proposals had been accepted by the Maternity Pathways Group as they are in alignment with their delivery plan and also the recommendations in the National Maternity Review to deliver more services from within neighbourhoods.
- A report on the development of an Older Person's Housing and Support Strategy; it was agreed that the Strategic Commissioning Group would oversee the development of the strategy, ensuring that the appropriate links are made with health and adult services.
- An update and discussion on Healthier Lancashire shared updated governance arrangements; this is on the Board's agenda for April.
- An update on the development of the Better Care Fund submission; it was agreed that quarterly monitoring would be carried out by the Strategic Commissioning Group and the submission will be approved by the Chairman of the Health and Wellbeing Board prior to submission to NHS England.
- A presentation from Lancashire Fire and Rescue Service on Public Service Integration and a proposal to develop a pilot that will develop their model of home fire safety checks into more holistic working with vulnerable people, to

join up with some of the work currently going in neighbourhoods; it was agreed that this was something that could be developed.

5.3 Does the information submitted include any exempt information? No

5.4 **List of Appendices:**
Appendix 3a – Minutes of the 20 January 2016 meeting
Appendix 3b – Minutes of the 24 February 2016 meeting

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

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Strategic Commissioning Group
Notes and Actions
20 January 2016, 9.30 – 11.30am
Conference Room 3 A, Bickerstaffe House

Present	Delyth Curtis, Director of People (Director of Children's Services), Blackpool Council (Chair) Lynn Donkin, Public Health Specialist, Blackpool Council Nikki Evans, Superintendent, Lancashire Constabulary Val Raynor, Head of Commissioning, Blackpool Council Helen Lammond-Smith, Head of Commissioning, Blackpool CCG Karen Smith, Director of Adult Services, Blackpool Council
Also present	Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council Paul Greenwood, Chair, Blackpool, Fylde and Wyre CVS Mike Crowther, Trustee, Blackpool, Fylde and Wyre CVS
Apologies	David Bonson, Chief Operating Officer, Blackpool CCG Gary Raphael, Chief Finance Officer, Blackpool CCG Dr Mark Johnston, Deputy Chief Operating Officer, Blackpool CCG Steve Thompson, Director of Resources, Blackpool Council Dr Arif Rajpura, Director of Public Health, Blackpool Council Liz Petch, Public Health Specialist, Blackpool Council Judith Mills, Public Health Specialist, Blackpool Council Scott Butterfield, Corporate Development and Research Manager, Blackpool Council Merle Davies, Director, Better Start

1.	**Welcome, introductions and apologies.** Del welcomed everyone to the meeting, apologies were given and introductions made.
2.	**Minutes and actions from the last meeting** **Children's Centres:** Helen advised that Mark Johnston had contacted Susan Green, the lead GP who was enthusiastic to be involved. Helen is linked to the Paediatric Strategy which is slightly different. **Action:** A full update on this is required at the February SCG meeting.
3.	**CVS Infrastructure Funding** Paul Greenwood and Mike Crowther attended to present the CVS business plan and request funding from the SCG partners to support the continuation of third sector infrastructure support. Mr Greenwood advised that the changing financial landscape was bringing greater

need to interact with the third sector, which included all manner of different types of organisations ranging from large national charities to small community groups.

CVS provide infrastructure support on two levels: grass roots and strategic. Investment will bring short, medium and long term benefits across a number of areas including resources, networks and partnerships, effectiveness and potential, and timeliness.

In terms of its contribution, Mr Greenwood advised that the third sector made a significant contribution to the health sector in its preventative work and that in continuing funding will give the stability required to enable the sector to further grow and develop in order to support the needs of the public sector. The importance of the third sector has been acknowledged in the Due North report.

A number of questions were asked regarding funding, which is currently through the Council, with some from Deputy Chief Exec's department and some from Public Health for ABCD work but this is due to run out in March 2016. The amount requested is larger than previous years because CVS needs strong leadership to deliver its objectives and the development work is an ongoing feature of this. The Fylde and Wyre element is funded separately through LCC; this is currently £23K per year. There has also been some funding from the Fylde and Wyre CCG for developing a service directory for GP's.

(In relation to Vanguard, Stuart Bond is leading the IT side and looking at IT systems across the board.)

In terms of the neighbourhood approach; plans are still in development around the ask of the voluntary sector, looking at developing qualified and unqualified staff and volunteers; there is a need to make sure it is all pulled together to incorporate the early action work, which overlaps with the neighbourhood approach. CVS needs to link into this work, including Better Start and the other key programmes in order to demonstrate how it makes a difference and where it fits within the wider picture.

It was raised that over the past few years CVS had not achieved its objectives so how would additional funding make a difference? There was agreement with this point and Mr Greenwood advised that if there was proper funding in place, CVS could make the best of its resources; there is a quarterly meeting of the Third Sector Forum, which is well attended; a newsletter with funding information and two sub-groups are currently being set up; there is also now a strong board in place who are committed to the core objectives.

Mike Crowther advised that governance and leadership are central and there is now a strong board and effort to have business plan, he asked what would happen if CVS wasn't there? He advised that third sector groups get lots of support to get funding and volunteers. It is about supporting and maintaining a vibrant sector that can help organisations to support others to get volunteers.

Del advised that from the local authority perspective, finances were extremely difficult with £90million to save by the end of 2017. The CVS Business Plan needs to link to particular areas of work – Better Start, Vanguard, Early Action, which are about building resilience.

While the Council is totally bought into the philosophy, it is looking to CVS to deliver but they have to be fit for purpose. Further discussion about what need to happen and opportunities may be useful regarding accessing other funding streams. In terms of transparency the Fylde and Wyre element of CVS needs to be separate from Blackpool.

	Nikki Evans commented that the police are also applying for external funding as their core funding is cut and that they fully appreciate CVS's situation. She also spoke of the public sector responsibility to make sure that CVS are embedded into structures so that they can capitalise upon and disseminate opportunities across the third sector. Karen Smith suggested that CVS need to work through the business plan and dovetail it to what is required, as there are lots of organisations delivering services but they are not delivering outcomes, and we don't want to overlap if it can be avoided. Del advised that there was a commitment to working with CVS and would review the current status of funding, looking at how other projects may link in, particularly around Vanguard and neighbourhood models. **Action: Del to write to CVS to advise of the outcome**
4.	**Intermediate Care Commissioning Review** Helen Lammond-Smith gave an update on progress against the implementation plan in order to deliver the new Intermediate Care Model from 1st April 2016. BTH and the Council will provide a hospital based and a home based model. Mapping has been undertaken with the acute trust, and a review of all intermediate care services in Blackpool. Further work is to be done with Arc to enhance the model and develop a new integrated service from April. **Action: Further updates will be brought to future meetings**
5.	**JSNA website** Stephen Boydell attended the meeting to give a demonstration of the new JSNA website which will be launched in April. It has been developed in a similar style to the Council's website, there are six areas following a life course approach. All of the information will be on a web page rather than as it is currently with a suite of pdf's on different subjects. Some topics will be updated with new data as often as it is published, others will be updated every three years, the JSNA is not a monitoring tool but is intended to provide background level data, however key health data will be updated regularly. The 'deep dive' areas do not change as often as the others. Stephen advised that there are still some bits missing but it is much more comprehensive than previously. The difficulty is that when Public Health were part of the PCT they had access to the data but now there is no legal right. We need to work with the CCG to provide data and an analysis of how it feeds into strategies. The JSNA will be launched in mid March
6.	**Next meeting: 17 February 2016**

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Strategic Commissioning Group
Notes and Actions
24 February 2016, 10 – 12pm
Conference Room, Blackpool Stadium

Present	Delyth Curtis, Director of People (Director of Children's Services), Blackpool Council (Chair) David Bonson, Chief Operating Officer, Blackpool CCG Nikki Evans, Superintendent, Lancashire Constabulary Dr Mark Johnston, Deputy Chief Operating Officer, Blackpool CCG Helen Lammond-Smith, Head of Commissioning, Blackpool CCG Dr Arif Rajpura, Director of Public Health, Blackpool Council Lynn Donkin, Public Health Specialist, Blackpool Council Karen Smith, Director of Adult Services, Blackpool Council Steve Thompson, Director of Resources, Blackpool Council
Also present	Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council Scott Butterfield, Corporate Development and Research Manager, Blackpool Council Tamasin Knight, Specialty Registrar in Public Health, Blackpool Council Gary Raphael, Chief Finance Officer, Blackpool CCG Jayne Bentley, Care Bill Implementation and Better Care Fund Project Lead, Blackpool Council
Apologies	Liz Petch, Public Health Specialist, Blackpool Council Judith Mills, Public Health Specialist, Blackpool Council Val Raynor, Head of Commissioning, Blackpool Council Merle Davies, Director Better Start, NSPCC

1.	**Welcome, introductions and apologies.** Del welcomed everyone to the meeting, apologies were given and introductions made.
2.	**Minutes and actions from the last meeting** **Children's Centre's** Helen updated on progress: a strategy group has been set up to look at national guidance on paediatrics, this is also picking up wider areas e.g. SEND to create get closer working teams. The children's centres work is another element to this. BTH is looking combining nine areas into three teams who will work with children in the community so children's centres would be ideal partners. **Action:** Helen to take the Children's Centre paper to the strategy group for discussion (the geographical footprint could be an issue) and update at next SCG. **CVS infrastructure funding** Del advised that a letter had been drafted advising CVS that while the Council, CCG and police could not offer funding from core budgets, there were other avenues that they could pursue if they aligned

	their business plan more closely with the objectives of existing and new projects e.g. HeadStart, FC Vanguard, Better Start and Early Action; and support could be provided to do this.
3.	**SCG work plan** Venessa presented the SCG work plan which summarised the work of the SCG since its review in July 2015 and looked forward at future items that would be discussed at the meeting; asking for contributions to the work plan for future items. Discussion of the work plan highlighted that while it was a good summary, it was a collection of 'things' and the group needs to have greater focus on discussing how we are working together and what the impact is. The SCG needs a stronger link with the Public Service Board and more time to discuss how the various work streams fit together. Suggestions for future pieces of work included mental health; and a separate piece of work to identify what support the public sector will need from the voluntary sector in the future to deliver emotional support, signposting, and health promotion; and how we can get to a point where that is clearly articulated, in order to develop and deliver a coherent and joined up approach to increasing community resilience and reducing isolation.
4.	**Better Care Fund** Jayne Bentley presented a refresh of the section 75 agreement for the Better Care Fund Submission for 2016-17. NHS England has sought to change the process, making it less bureaucratic. Planning guidance was published on 23 February and a draft submission was due the following week. Last year's contributions from the CCG and LA are on appendix C; the CCG contribution is £1million less than originally anticipated due to the extensivist scheme costing less, there is no legal impact. Discussion followed and it was agreed that the SCG needed to give further consideration to the schemes included in the BCF submission and decide if they were to be included in the next submission. Karen highlighted the community contract elements, querying whether they could be brought into BCF to enable monitoring and management of outcomes. Further work was identified to ensure the correct figures were being used, and to clarify what is included and what is not. The SCG would hold responsibility for the BCF and a further meeting to discuss the issues would be arranged to include Mark Johnston, David Bonson, Pat Crawford, Jayne Bentley, Mark Golden, Del Curtis, Karen Smith and Helen Lammond-Smith (to pick up conversations around a Lancashire pooled budget for LD). Further discussion followed regarding how we need to make more use of evidence to make decisions about decommissioning projects/services that are not delivering outcomes. Some projects need longer to embed. If we have more collective spend in the BCF we can look more closely at those decisions. The BCF must be signed off by the HWB in April before submission to NHS England. **Action: updated submission to be brought to next meeting for further discussion**
5.	**Healthier Lancashire** Gary Raphael attended to present the item; he presented a diagram of proposed governance

structures, explaining that the Joint Committee consisted of nine CCG's from across Lancashire and Cumbria and that HL would follow the same geographical footprint as the NHS STP.

Describing the governance structure diagram he advised that there is a proposed Joint Committee of CCG's including Cumbria as the STP footprint includes South Cumbria CCG. The Joint Committee makes legal decisions amongst other things. The STP footprint is decided by the locality and NHS England; lots of current workstreams include South Cumbria.

Del expressed concerns that while local authorities sit on the JC, they have no voting rights, which is important as the decisions may have a wider impact. Gary advised that it needs to be synchronised with the Combined Authority and that legally for the NHS, only CCG's can form Joint Committees, which presents a conflict when the national direction of travel is to integrate health and social care.

Further discussion took place regarding the role of the Programme Board and the notion of a joint Health and Wellbeing Board in terms of fit with the Joint Committee, especially regarding workstreams such as acute transformation, where decisions are political, and the buy in of the HWB will be crucial.

A key group is the Communications and Engagement Key group; this needs to involve HWB's and Overview and Scrutiny Committees.

There is a Care Professional Board, which will ensure that staff groups are kept informed, and a number of large workstreams some of which will need to be led by the LA e.g. prevention, and the care sector.

There are five local health and care economy boards, it needs to be agreed what will happen at the local economy level and what happens at HL level. The transformation funding will go through the STP footprint; there are some tensions between the STP process and HL.

There is still a lot of thinking to do; once the Joint Committee is established we can move into the next phase. The overall solution is to deliver better services and save £800m.

The STP includes some areas relating to children, for example mental health and child obesity - how will these be managed?

Further discussion followed around savings: part of the process is about understanding what can be taken out of the system in order to transition to more cost effective services; Blackpool, Fylde and Wyre's share is approx. £350 million of £800 million in total.

Comments expressed the view that the governance does not meet the objectives of the programme and it was advised that we have to work within the current legal framework.

Del advised that we need to look at the membership of some of the groups to ensure appropriate representation.

Further discussion took place around what will be included in the remit for the FC, for example LD and children's mental health and the need to define what we do at each level. The biggest priority for HL is to reconfigure the acute trusts, while for the LHCE it will be around scaling up some of the

	good work. Gary advised that he will be writing to request funding from the local authority and other organisations. **Action: Regular updates will be brought to the SCG and HWB**
6.	**Intermediate care** Helen Lammond-Smith updated the group on the implementation of new intermediate care services. She advised that currently GP cover is being arranged for the facility at Arc and possibly Clifton. There is a shortfall in staffing around Occupational Therapy and physiotherapy but the new model is moving ahead.
7.	**Sustainability and Transformation Plan** Mark Johnston advised that there has been no decision made about how to take the STP forward other than what has already been described in earlier HL discussion.
8.	**Vanguard – new models of care** Mark advised that value proposition has been submitted to NHS England; however the enhanced primary care model will not be rolled out until the finances have been agreed.
9	**Date of next meeting: 16 March 2016**

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Karen Smith, Deputy Director of People (Adult Services)
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	20 April 2016

TRANSFORMING CARE UPDATE

1.0 Purpose of the report:

1.1 To update the Health and Wellbeing Board on progress of the Transforming Care programme.

2.0 Recommendation(s):

2.1 To note the update.

3.0 Reasons for recommendation(s):

3.1 The Health and Wellbeing Board has a key leadership role to play in ensuring that the commitments and priorities of the Transforming Care programme are achieved.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is Communities: Creating stronger communities and increasing resilience

5.0 Background Information

5.1 The report provides a summary of the requirements of the national Transforming Care programme, and sets out local progress in the implementation of the Pan-Lancashire Transformational Plan for people with a learning disability and/or autism and challenging behaviour or a mental health condition.

5.2 Taking into account variations in commissioning processes, local priorities and composition of community learning disability teams a localised version of the Pan-Lancashire transformational plan has been developed for Blackpool and aligned to the overarching plan for Lancashire.

5.3 The Transforming Care Programme has evolved from the Winterbourne View Concordat published by the Government in 2012. Since the programme was launched in 2014, there has been increased expectation and pace around the agenda paralleled by an increase in reporting to and guidance from NHS England as to how transformation should happen.

5.4 Care and Treatment Reviews
Since December 2014 Care and Treatment Reviews (CTRs) have become a requirement of the Transforming Care programme and were initially designed for individuals detained/placed in hospitals to:

- assess whether or not they are appropriately placed
- determine their future requirements
- focus on establishing discharge

Care and Treatment Reviews in these instances take place every six months.

5.5 Care and Treatment Reviews are now embedded as "business as usual" and expanded to include a pre and post admission process and a Blue Light process for unplanned/emergency admissions. Care and Treatment Reviews have also been adapted to take account of children and young people with a diagnosis of autism which is aligned to Education, Health and Care (EHC) plans.

5.6 The approximate total cost for each Care and Treatment Reviews is £800; previously funding was recharged to NHS England. However, from 2016/17 Clinical Commissioning Groups will be expected to meet this cost directly.

5.7 A further requirement of the transforming care programme is for all localities to develop a register of people who are at risk of admission and to work closely to monitor this register with agencies (Health, Social Care and Education). Blackpool has developed an at risk register which includes children and young people with Learning Disability and Autism, and arrangements are being put in place with Children's Services and Special Education and Disabilities Team (SEND) team to ensure the

information is maintained.

5.8 Transforming Care Next Steps and National Plan
In June 2015, NHS England published Transforming Care Next steps an ambitious programme of work to further accelerate work to transform community services. As part of this five fast track sites were established to strengthen local services and return individuals to their communities. These sites were identified as having high numbers of individuals with a Learning Disability and/or Autism in hospital settings. These are:

- Greater Manchester and Lancashire;
- Cumbria and the North East;
- Arden, Herefordshire and Worcestershire;
- Nottinghamshire;
- Hertfordshire.

The learning and best practice from these sites will be shared with non-fast track areas across the country.

5.9 Each site received support from NHS England to develop a transformational plan, setting out a road map for strengthening (and where appropriate) redesigning local services for people cared for by the transforming care programme and the wider learning disability population. This was supported by £10million transformational fund which the Clinical Commissioning Group has match-funded. Plans were approved by NHS England's national team and signed off by respective Health and Wellbeing Boards in late summer/autumn 2015.

5.10 In October 2015, NHS England along with the Local Government Association (LGA) and the Association of Directors of Adult Social Care (ADASS) published "Building the right support – a national plan to develop community services and close inpatient facilities" the plan is accompanied by a national service model.

5.11 Building on the fast track programme and ambitions of the national plan, 48 transforming care partnerships have now been established across the country to build up community services and close inpatient facilities by March 2019.

5.12 Blackpool forms part of the Lancashire Transforming Care Partnership which is responsible for ensuring that the agreed priorities set out in the Pan-Lancashire Transformational Plan are realised.

5.13 As part of the national plan, NHS England confirmed that payments would be available to individuals who have been in medium and low secure placements for five or more years. Currently Individuals in medium and low secure settings are funded through NHS England's Specialised Commissioning Department; it is the intention that this resource will follow the patient following discharge. Funding will cover both

care and accommodation costs and be transferred to the local authority. For individuals in hospital settings for less than five years, CCG's and local authorities are expected to agree arrangements for funding community packages.

5.14 Local and Regional progress

Since the approval of the pan-Lancashire transformation plan in September 2015 (which is supported by £1.5million fund, match-funded by the 8 Clinical Commissioning Groups) to support development of new models of care, a series of workstreams/priority areas have been identified.

- Enhanced Advocacy services
- Development of the specialist provider market
- Discharge Co-ordination
- Development of integrated Community Learning Disability Team and Community Hubs
- Workforce Development (positive behavioural support and challenging behaviour approaches and best practice)
- Specialist Accommodation
- Enhanced Respite and Crisis provision
- Positive Behavioural Support (PBS) schemes to be piloted by Fylde and Wyre Clinical Commissioning Group and East Lancashire Clinical Commissioning Group

5.15 The plan also takes account of and is aligned to the principled set out in the national service model.

5.16 The plan is project managed by a Transforming Care programme lead based at Chorley and South Ribble, and Preston Clinical Commissioning Groups. Individual project plans and engagement and information sharing events for each identified workstream have been held or are planned to ensure sign up and contribution from all appropriate stakeholders. Work is currently focussed on ensuring resettlement for patients who require discharge between March – June 2016).

5.17 Co-production is threaded throughout and a programme of engagement and involvement activities for service users, families, carers and independent advocates is in place and underway.

5.18 The priority areas outlined above are also reflected in Blackpool's local transforming care action plan. However taking into account local variations, the four key priorities for Blackpool are:

- Market Development
- Specialist Accommodation
- Crisis and Respite provision
- Workforce Development

Blackpool is working collaboratively with pan-Lancashire transforming care partnership and NHS Midlands and Lancashire Commissioning Support Unit (CSU) colleagues to shape the provider and accommodation market, to ensure there is sufficient level of specialist care and support providers and a suitable mix of housing to meet the needs of people that fall under the transforming care criteria. A pan-Lancashire accommodation strategy will be developed to take some of this work forward and a preferred provider list of 'complex' care and support providers will be put in place by the Commissioning Support Unit for local areas to procure and commission services from. A programme of workforce development is underway with national funding secured through Health Education England/Skills for Care to upskill in-house and external providers – embedding Positive Behavioural Support (PBS) and Challenging Behaviour approaches. Blackpool Council successfully bid for just over £50,000 to roll out Positive Behavioural Support training locally.

5.19 Patient cohorts

Across Lancashire there are ninety-three patients that fall under the transforming care programme. In total forty-seven patients are in Clinical Commissioning Group funded cohorts and forty-six patients in specialised commissioned funded cohorts. Of these patients there are two in the Clinical Commissioning Group cohorts and five in the specialised commissioned cohorts for Blackpool. Of these seven, one is eligible for a dowry.

Number of clients	Current placement	Funded by	Discharge	Eligible for Dowry
1 (end of life)	Discharged from Calderstones to community placement	Specialised Commissioning	Feb 2016	Yes
2*	Rehabilitation	Blackpool CCG	June 2016	No
1	Short Term Assessment and Treatment (via Prison Transfer)	Specialised Commissioning	TBC at CTR	No
1*	Calderstones	Specialised Commissioning	June 2016	No
2	Calderstones	Specialised Commissioning	2018-19	Yes
1	Rampton	Specialised Commissioning	2018-2019	Yes
1	The Harbour	Blackpool CCG	TBC at CTR	No

5.20 Care and Treatment Reviews have been undertaken for each patient and families and carers are involved in the process. Discharge planning including care, support and accommodation requirements is underway for the three individuals with identified discharge dates of June 2016.

5.21 Step down accommodation has also been identified locally and a bid submitted to NHS England's Winterbourne Resettlement Fund to secure the capital monies needed to re-develop elements of the property. The outcome of the application is due in April 2016. Funding arrangements for individual packages is being progressed with Blackpool Clinical Commissioning Group. The remaining clients have been assessed as being appropriately placed and are not ready for discharge.

5.22 Supported by the NHS Midland and Lancashire Community Support Unit (CSU), Lancashire Transforming Care Partnership is currently considering options for pooling budgets and has drawn up a financial protocol which sets out the scope and process for pooling or aligning resources which has been agreed in principle by the eight Clinical Commissioning Groups and three Local Authorities.

5.23 Reporting

Clinical Commissioning Group and local authority reporting requirements on progress of the Transforming Care Programme has increased substantially over the past four years. In addition to information shared at Health and Wellbeing Board and Clinical Commissioning Group Governing Bodies an overview of what is reported, to whom and how often is summarised below:

- Assuring transformation data on individual patients is submitted to the Health and Social Care Information Centre (HSCIC) on a monthly basis by Blackpool's Integrated Learning Disability Community Team Manager. This is a new reporting mechanism replacing Winterbourne quarterly returns to NHS England.

- Weekly sub-regional reporting to NHS England on patient activity is submitted via Blackpool Clinical Commissioning Group.

- The operational arm of the Transforming Care Partnership meets on a fortnightly basis to review implementation of the pan-Lancashire transformational plan and progress against key actions. This is attended by members of Blackpool's transforming care project group. The Transforming Care Partnership reports into the Collaborative Commissioning Board (CCB).

- Blackpool's Transforming Care Project Group meets bi-monthly to deliver and review progress against local priorities and ensure continued alignment with the Pan-Lancashire plan. This group in turn reports to Blackpool's

Transforming Care Steering group chaired by the Director of Adult Services, Blackpool Council.

5.24 The requirements of the Transforming Care Programme are substantial given the small patient group, however the process is being managed appropriately in accordance with patient needs and there are high levels of proactive partnership working and collaboration across local and regional partners to realise the wider ambitions of the programme across the Lancashire footprint.

5.25 Does the information submitted include any exempt information? No

5.26 **List of Appendices:**

Appendix 4a: "Building the right support – a national plan to develop community services and close inpatient facilities"

Appendix 4b: Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition - Service model for commissioners of health and Social Care services

6.0 Legal considerations:

6.1 To meet the requirements of the Transforming Care Programme, Blackpool Council and Blackpool Clinical Commissioning Group must work within the legal requirements of the Mental Health Act 1983 and the Mental Capacity Act 2005.

7.0 Human Resources considerations:

7.1 The Integrated Community Learning Disability Team (CLDT), (comprising of health and social care professionals from the Blackpool Council's Adults Social Care Team, Psychology services via Lancashire Care Foundation Trust/Blackpool Teaching Hospitals Community Health and Blackpool Clinical Commissioning Group) is responsible for co-ordinating and reviewing care plans of people with learning disabilities in social care and health placements. The Contracting and Commissioning Team within Blackpool Council is responsible for coordinating contract monitoring arrangements including quality monitoring of Blackpool Council and NHS contracted services respectively.

8.0 Equalities considerations:

8.1 A Lancashire wide Joint Strategic Needs Assessment report highlighted that people with learning disabilities are one of the most excluded groups in the community:

- Nearly half live in the most deprived areas of Lancashire
- Fewer than 15% are in employment across Lancashire and in Blackpool this figure is considerably lower.
- The housing needs of people with learning disabilities are considerable and will increase.
- People with learning disabilities experience much poorer health outcomes across a range of conditions including respiratory diseases, sensory impairment, gastrointestinal cancer, anxiety and depression, dementia and challenging behaviour.
- Prevalence and need is increasing whilst available budgets have been decreasing and are likely to continue to decrease.
- This has major implications for how services are delivered and will require a different approach to commissioning and developing co-produced services.

9.0 Financial considerations:

9.1 As part of the national plan, NHS England has confirmed that additional payments will be available to individuals in medium and low secure placements for five or more years. For Blackpool one eligible client was identified.

9.2 For those individuals in hospital settings for less than five years of which three have identified discharge dates for Blackpool. Blackpool Council and Blackpool Clinical Commissioning Group are progressing arrangements for funding of these packages.

9.3 In addition work is underway through NHS Midland and Lancashire Community Support Unit (CSU) and Lancashire Transforming Care Partnership to explore the scope of pooling or aligning resources, and a financial protocol has been agreed in principle by the eight Clinical Commissioning Groups and three local authorities. As a first step each area has been asked to consider local pooling arrangements before consideration is given to a pan-Lancashire approach.

10.0 Risk management considerations:

10.1 The Board has a key leadership role to play in ensuring that the commitments of the Transforming Care programme are achieved in respect of safeguarding and protecting the most vulnerable. A failure to keep adults at risk of abuse safe from avoidable harm represents not only a significant risk to residents but also to the reputation of the Council, Blackpool Clinical Commissioning Group and care

providers. Although safeguarding must be the concern of all agencies working with vulnerable adults, the Council is the lead agency and is responsible for the co-ordination of the multi-agency Safeguarding Board.

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

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Local Government Association

directors of adass adult social services

NHS England

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

October 2015

Building the right support

A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

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Contents

Foreword 4

1. Executive summary 5

2. The journey to date 9

- Background 9
- Fast tracks 12
  - Greater Manchester 13
  - Lancashire 14
  - Cumbria and the North East 15
  - Hertfordshire 16
  - Nottinghamshire 17
  - Arden, Herefordshire and Worcestershire 17

3. The new services we need 22

- Improving services for a heterogeneous group 22
- The service model 24
- Reduced need for inpatient services 27

4. Working together to provide new services 35

- Transforming care partnerships 35
- The challenge 36
- Supporting local areas 37
- Monitoring progress 41
- Financial underpinnings 43

Conclusion 45

Annex A – Proposed CCG clusters for transforming care partnerships 46

Annex B – Workforce development 52

Annex C – Notes on data used in this document 55

Foreword

Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

As a society, we are on a long journey to make that simple vision a reality. We have made enormous strides over several decades. But for a minority of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition[1], we remain too reliant on inpatient care - as they and their families have been telling us loud and clear.

It is for that reason that, in February 2015, NHS England publicly committed to a programme of closing inappropriate and outmoded inpatient facilities and establishing stronger support in the community, and promised that further details would follow later in the year. This plan meets that commitment.

We know it comes at a time when many people with a learning disability and/or autism, as well as their families/carers are frustrated - that change has been limited and slow, particularly following the appalling scandal at Winterbourne View. We know too that thousands of frontline carers, clinicians, providers and commissioners want to make progress.

This plan sets out how we will do so: supporting local leadership and making available new investment to kick-start change. It means that we now have an opportunity – to make real the rights of people with a learning disability and/or autism, and to help thousands of people lead happier lives.

We know that this challenge is achievable because many parts of the country are already successfully doing it. There is good practice across the country to replicate, and the skills and expertise of thousands of families and front-line staff to build on. 'Fast track' areas across England are starting to show what kind of transformational change is possible with strong local leadership building a new generation of community-based services.

Now it is time to deliver across the whole country. This plan sets out how we intend to do so – working with people with a learning disability and/or autism, families, staff, clinicians, providers, and commissioners.

Jane Cummings,
Chief Nursing Officer, England

Ray James, President, Association of Directors of Adult Social Services

Sarah Pickup, Deputy Chief Executive, Local Government Association

Dominic Slowie, National Clinical Director for Learning Disability, NHS England

[1] Hereafter people with a learning disability and/or autism

1. Executive summary

The journey to date

1.1 Over many decades, as a society we have significantly reduced our reliance on institutional care to support people with a learning disability and/or autism, closing asylums, campuses and long-stay hospitals. For a minority of people however, there is still an over reliance on inpatient treatment for people who could, given the right support, be at home and close to their loved ones.

1.2 Over the last few years hundreds of people from hospital have been supported to leave hospital – but others are admitted in their place, often to inappropriate care settings, so the number of inpatients remains steady. We have not made enough progress when it comes to changing some of the fundamentals of care and support.

1.3 To make this permanent we need a change in culture, a shift in power to individuals and a change in services. We need to see people with a learning disability and/or autism as citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. And we need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

1.4 To speed up this process and to help shape a national approach to supporting change, six 'fast track' areas[2] drew up plans over the summer of 2015 and are already making a difference on the ground. Together they envisage shifting money into community services in order to reduce their usage of inpatient provision by approximately 50% over the coming three years. Their plans will result in the development of a range of new community services and the closure of hospital units, including the last standalone learning disability hospital in England.

1.5 This document describes how we intend to build on our experience with fast tracks to implement change across the rest of the country.

The new services we need

1.6 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. Some will have a mental health problem which may result in them displaying behaviour that challenges. Some, often with severe learning disabilities, will display self-injurious or aggressive behaviour unrelated to any mental health condition. Some will display behaviour which can lead to contact with the criminal justice system. Some will have been in hospital for many years, not having been discharged when NHS campuses or long-stay hospitals were closed. The new services and support we put in place to support them in the community will need to reflect that diversity.

[2] Greater Manchester; Lancashire; North East and Cumbria; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire

1.7 A national service model, developed with the help of people with lived experience, clinicians, providers and commissioners, outlined in this document and published in full alongside it, sets out the range of support that should be in place no later than March 2019. It should be read in tandem with this plan.

1.8 Implementing this model, and giving people greater power over the services they use, will result in a significantly reduced need for inpatient care. We expect that as a minimum, in three years' time no area will need capacity for more than 10-15 inpatients per million population in clinical commissioning group (CCG) commissioned beds (such as assessment and treatment units), and 20-25 inpatients per million population in NHS England-commissioned beds (such as low-, medium- or high-secure services).

1.9 These planning assumptions will mean that, at a minimum, 45 – 65% of CCG-commissioned inpatient capacity will be closed, and 25 – 40% of NHS England-commissioned capacity will close, with the bulk of change in secure care expected to occur in low-secure provision. Overall, 35% - 50% of inpatient provision will be closing nationally with alternative care provided in the community. The change will be even more significant in those areas of the country currently more reliant on inpatient care. In three years we would expect to need hospital care for only 1,300-1,700 people where now we cater for 2,600. This will free up money which can then be reinvested into community services, following upfront investment.

1.10 These planning assumptions should be seen as the starting point. Commissioners should, working with people with a learning disability and/or autism, be ambitious in thinking about how much further they can go, starting not from the point of what services they have currently but what support people need to live the best possible life.

1.11 Just like the rest of the population, people with a learning disability and/or autism must and will still be able to access inpatient hospital support if they need it. What we expect however is that the need for these services will reduce significantly. The limited number of beds still needed should be of higher quality and closer to people's homes.

1.12 For those that do need this more specialist support in hospital, their length of stay should be as short as possible. We will work with providers, commissioners and clinicians to reduce length of stay overall and ensure areas learn from best practice – for instance one 'fast track' area aims to reduce length of stay in assessment and treatment services to an average of 85 days.

Delivering change

1.13 To achieve this systemic change, 49 transforming care partnerships (commissioning collaborations of CCGs, NHS England's specialised commissioners and local authorities) are mobilising now. They will work with people who have lived experience of these services, their families and carers, as well as key stakeholders to agree robust implementation plans by April 2016 and then deliver on them over three years.

1.14 An alliance of national organisations will support these transforming care partnerships to deliver on this ambitious agenda, including NHS England, Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Health Education England (HEE), Skills for Health, Skills for Care, the Care Quality Commission (CQC), NHS Trust Development Authority (TDA), Monitor, and provider representative organisations, working closely with people with a learning disability and/or autism as well as their families/carers.

1.15 In every part of the country there are people with the skills and experience to deliver effective care and support. These people can be found within health and social care services, and amongst the families and carers who support individuals in their own homes. Successful delivery will depend on them. Their insight will be key to designing, developing and launching new services in the community, and their skills and experience will be central to delivering them.

1.16 As part of this alliance for delivery, and working alongside local commissioners, we will work with provider organisations to mobilise innovative housing, care and support solutions in the community. Our collaboration will focus on supporting commissioners to redesign services, scaling up community-based services, developing the workforce, accessing investment to expand community services, and securing the capital to deliver the new housing needed.

1.17 A new financial framework will underpin delivery of the new care model:

- Local transforming care partnerships will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way that achieves better results
- To enable that to happen, NHS England's specialised commissioning budget for learning disability and autism services will be aligned with the new transforming care partnerships
- CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.
- For people who have been in hospital the longest, the NHS will provide a 'dowry' – money to help with moving people home
- During a phase of transition, commissioners will need to invest in new community support before closing inpatient provision. To support them to do this NHS England will make available up to £30 million of transformation funding, to be matched by CCGs, over and above the £10 million already made available to fast track areas

- In addition to this, £15 million capital funding over three years will be made available and NHS England will explore making further capital funding available following the Spending Review
- From November 2015, *'Who Pays'* guidance will be reformed to reduce financial barriers to swift discharge

1.18 Before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further.

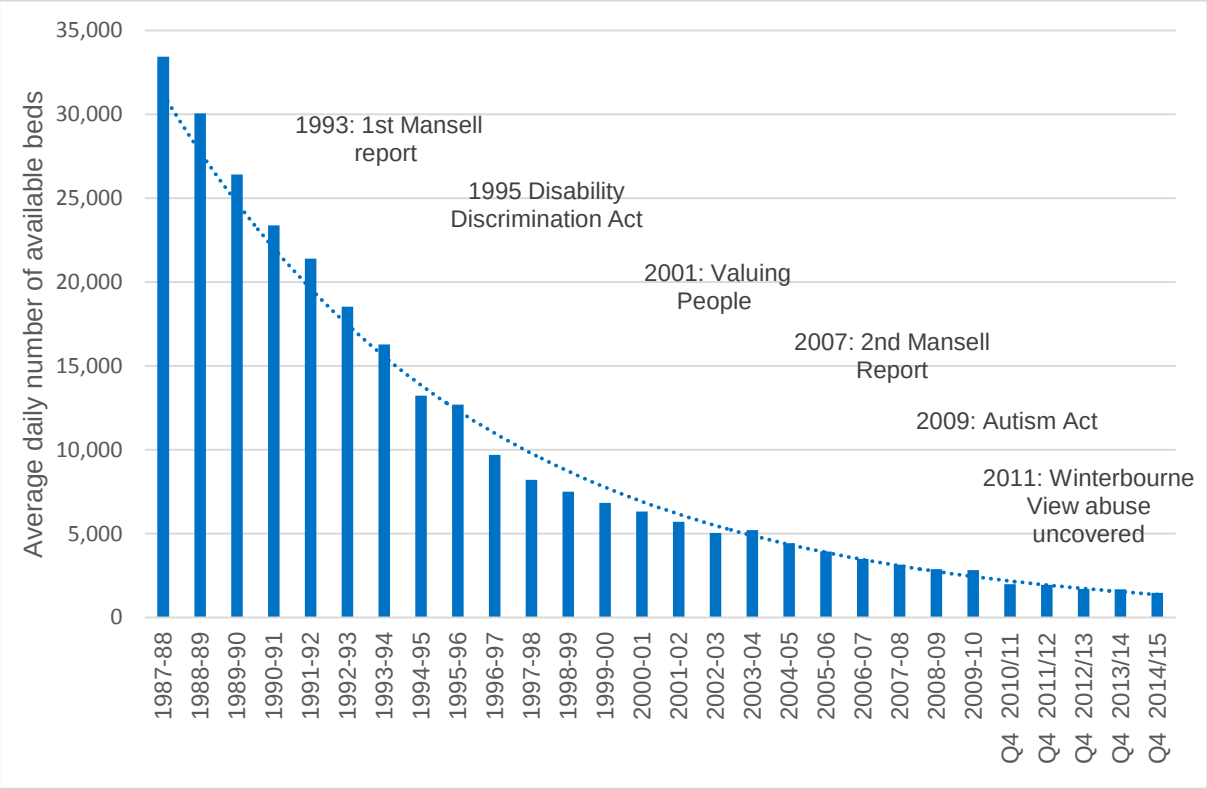
2. The journey to date

Background

2.1 Historically, from the asylum to the long stay hospital, too often people have been routinely placed in institutions away from their homes and communities.

2.2 Rightly, most of these institutions were closed and now the majority of people with a learning disability and/or autism will never come into contact with the types of hospitals – including assessment and treatment services – that are discussed in this document.

Figure 1: NHS learning disability beds since 1987[3]



2.3 The scandal at Winterbourne View, however, was not just an individual episode of appalling abuse. It also highlighted the fact that despite the progress we have made as a society in recent decades, for a small number of people we remain too reliant on hospital care, particularly in some parts of the country (see figure 2 and figure 3).

[3] Data taken from KH03 collection from all NHS organisations that operate consultant-led beds open overnight or day only. Changes to the way data is collected mean only Q4 data provided from 2010/11. More information: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

Figure 2: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015)[4]

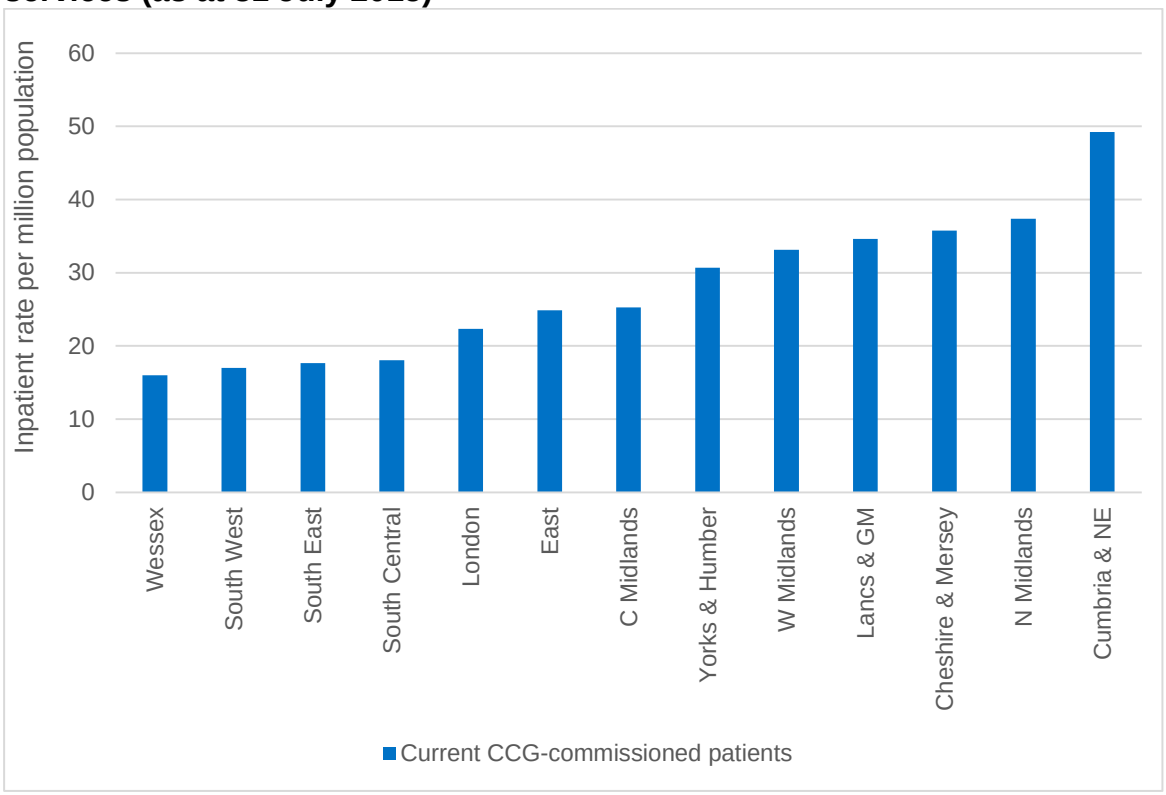
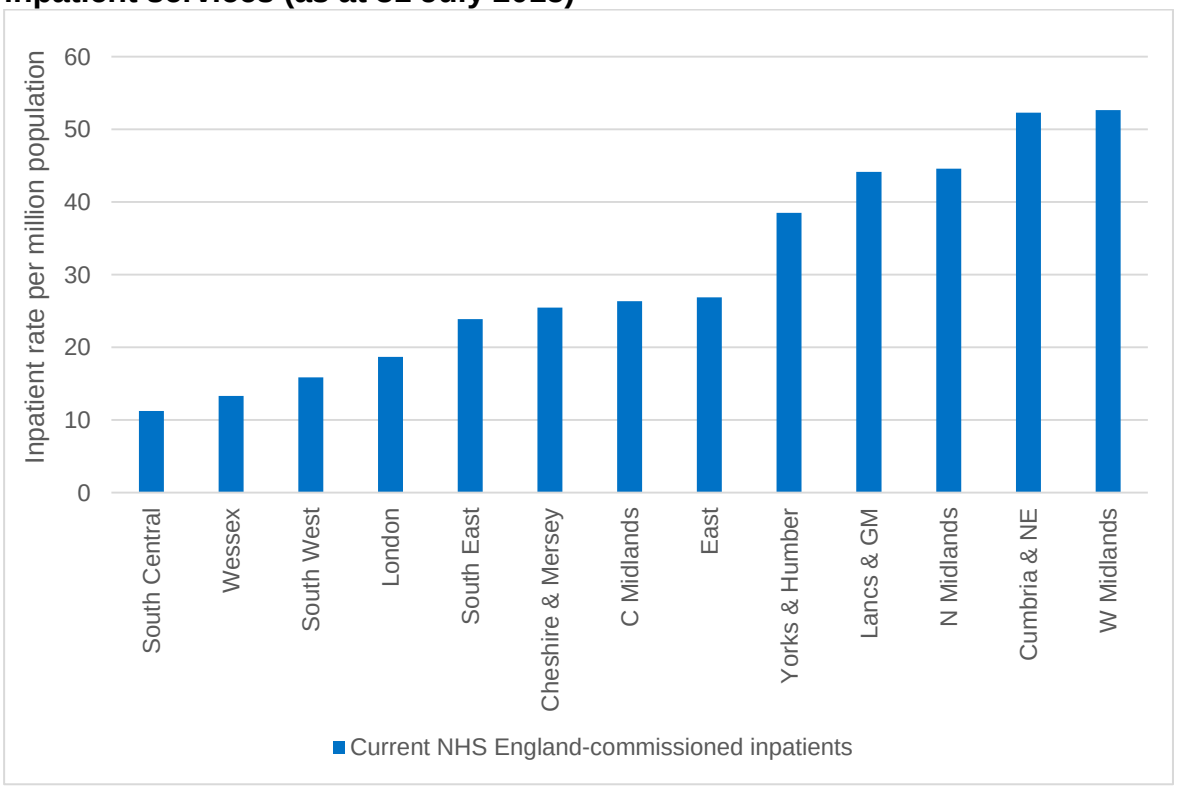


Figure 3: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015) [5]



[4] See Annex C for further notes on the data used in these charts
[5] See Annex C for further notes on the data used in these charts

2.4 To address this longstanding problem recently there has been a renewed push to address these issues with, for instance:

- The CQC introducing a new approach to inspecting learning disability hospitals and the care of people with a learning disability and/or autism in acute hospitals
- New data systems put in place to track the care people are receiving
- The Department of Health's consultation *No Voice Unheard, No Right Ignored: a consultation for people with learning disabilities, autism and mental health conditions* looked at how to strengthen rights, incentives and duties in the wider system, focusing on how people can be supported to live independently in their communities and make choices in their lives. Views were sought on a range of ideas intended to strengthen or build upon existing policies, including possible changes to legislation. The Government will shortly set out the actions it proposes in response to the consultation

2.5 In addition to this, NHS England has rolled out a programme of Care and Treatment Reviews (CTRs) - reviews of individual patients' care to prevent unnecessary admissions and avoid lengthy stays in hospital. These CTRs bring together:

- People with a learning disability and/or autism and their families/carers
- Independent expert advisors – one clinical and one expert by experience
- The responsible commissioner and others involved in the persons care and treatment

These reviews look to see if someone's care is safe, effective and whether they need to be in hospital as well as whether there is a plan in place for the future. By mid-September 2015 over 2,020 CTRs had been completed since their introduction in October 2014. Between March and August 2015, over 750 people in hospital were discharged or transferred.

2.6 Progress has been made. Hundreds of people previously in hospital are now living in their own homes, and the foundations for future progress have been laid.

2.7 Despite this, we know the most significant changes needed lie ahead. For all the progress discharging individuals from hospital, the number of people not living at home remains similar to what it was when CTRs were introduced. Admissions remain high, and some people are in hospital when they are ready to be discharged because the right support is not available.

2.8 As Sir Stephen Bubb highlighted in his report for NHS England[7], we need to change the mix of services available on the ground - shifting our investment into better support in the community and closing some inpatient services. To do this "we need both more 'top-down' leadership...and from the 'bottom up'

[7] http://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf

more empowerment for people with learning disabilities and/or autism and their families."

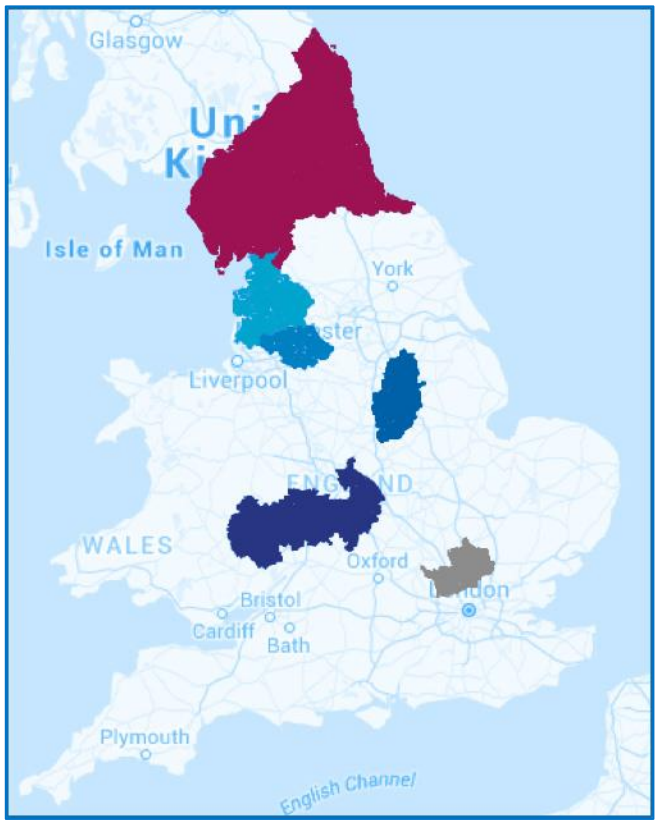
2.9 Six 'fast track' areas have begun that process, and this plan sets out how we will now support the rest of the country to follow suit.

Fast tracks

2.10 Over the summer of 2015, NHS England, LGA and ADASS supported six 'fast track areas'[8] (collaborations of CCGs, local authorities and NHS England specialised commissioners) to draw up plans for service transformation. A £10 million fund was made available to these areas to help fund transitional costs and speed up implementation.[9]

2.11 These areas are highly diverse – in terms of demography, patient flows, provider landscapes, deprivation, urban and rural communities – allowing NHS England, LGA and ADASS to test our approach to a range of different challenges that different communities in England will face as they seek to transform services – from developing the local workforce to designing new community health services to ensuring that funding flows enable change.

Figure 4: Fast track areas



[8] Greater Manchester; Lancashire; Cumbria and the North East; Arden, Herefordshire and Worcestershire; Nottinghamshire; Hertfordshire

[9] The NHS and local government in these areas spend many millions on care for people with a learning disability and/or autism. The £10 million is not intended to fund all the costs in that new service model

2.12 Each fast track has published its plan and fast track areas are now engaging with local communities and providers to help shape delivery.

2.13 Taken together, fast track plans envisage that bed usage across all six areas will reduce by approximately 50% over the coming three years, freeing up tens of millions of pounds which will be invested in community-based support to prevent hospital admissions.

2.14 Below is a summary of some of the actions that each of the fast track areas are implementing.

Greater Manchester

2.15 The devolution deal for Greater Manchester has resulted in new powers and responsibilities for local leaders. In describing their joint ambition for change, they have prioritised the improvement of services for people with a learning disability and/or autism.

2.16 In terms of bed usage, the Greater Manchester Fast Track uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust, which is also used to a large degree to provide care to patients from Lancashire. As such their plans are being jointly developed with the Lancashire Fast Track.

2.17 Their ambition is to reduce their use of 130 inpatient beds by 50%: from 77 non-secure beds to 30 (a 60% reduction) and from 53 secure beds to 35 (a 34% reduction) by 2018/19. To re-provide this care they are creating intensive community support services with robust case management and discharge coordination across the area to enable individuals to receive care at home and improve their care experience.

2.18 Recognising that occasionally the needs of individuals can increase, they are also investing, this year, in six local crisis beds and an in-reach/outreach team providing safe short intensive support when needed.

2.19 Furthermore they are in the process of creating an innovative housing scheme that will ensure round-the-clock care for people with a learning disability and/or autism from early next year.

2.20 A cornerstone of the plan is their intention to retain and build the confidence of the staff, as well as families/carers, to improve quality of care in the community. To do this they intend to deliver a three year family and staff development programme.

2.21 In addition, to monitor the impact of the plan by March 2017 - as part of the wider Greater Manchester Public Sector Reform Programme - there will a formal evaluation assessing its impact over an 18 month period.

Lancashire

2.22 Similarly to Greater Manchester Fast Track, Lancashire uses a range of hospital providers but has a significant number of inpatients in Calderstones Partnership Foundation Trust.

2.23 Lancashire intends to reduce their reliance on non-secure beds by 70% and substantially reduce the numbers of people who come into contact with secure services. This high ambition will be achieved by focussing on putting in place high-quality individual packages of care and creating a hub and spoke community support model (expected to be fully operational by March 2018). They will develop:

- An integrated community learning disability team across the whole of Lancashire
- Crisis intervention and support services across the area
- A small number of community-based assessment and treatment services to prevent unnecessary out of area placements

2.24 To help with developing these services, Lancashire is rolling out a local engagement plan to ensure people impacted by these changes are fully involved in the building up of community capacity and shaping the services they use.

2.25 Their intention to retain staff to work in new models of care is a vital part of the plan. A comprehensive development programme will be rolled out this year, with two CCGs implementing Positive Behavioural Support (PBS) training and a scheme designed to offer rights-based training to improve access to mainstream health and social care services for people with a learning disability and/or autism.

2.26 Finally, in line with the national service model, they expect from April 2017 to reshape advocacy services across the region and develop a more robust model for delivering short break services.

- **Calderstones Partnership NHS Foundation Trust**

2.27 A key plank of the plans being developed in Lancashire and Greater Manchester will be to close and re-provide services offered by Calderstones Partnership NHS Foundation Trust.

2.28 Calderstones Partnership NHS Foundation Trust is the only remaining standalone learning disability hospital trust in England with 223 beds. They have initiated a collaboration with Mersey Care NHS Trust driven by an ambition to develop person-centred care, and sustainable services that stand the test of time, underpinned by a strong quality, clinical and financial case for fundamental changes in local secure mental health and learning disabilities care.

2.29 The plan is for Mersey Care NHS Trust to take over Calderstones Partnership NHS Foundation Trust, which from July 2016 will cease to exist.

2.30 The plans developed by Greater Manchester and Lancashire Fast Tracks with NHS England Specialised Commissioners, subject to consultation, will implement a new service model resulting in a substantial reduction of beds (>60% fewer than currently).

2.31 NHS England will also cease commissioning secure services on the Calderstones site.

2.32 All hospital beds on the current Calderstones site will therefore, subject to consultation, close and be re-provided over the next three years on a case by case basis for each patient, in the community or in new state of the art units elsewhere in the North West, and the Calderstones site will close.

2.33 Ongoing consultation and engagement with people with learning disabilities, their families and carers will be central to the process of change and the commissioners and providers involved are committed to ensuring that patients and families are always involved in decisions about their care and support.

2.34 Calderstones Partnership NHS Foundation Trust and Mersey Care NHS Trust have appointed a joint Medical Director to provide clinical leadership in the process of bringing these two organisations together. The post holder will help sustain and build world class leaders and staff, enabling them to be part of the future.

2.35 The trusts are already focussing on a range of joint quality initiatives with staff to improve quality and increase efficiency - for instance, they have initiated an international collaboration with Stanford Risk Authority (Stanford University) to manage risk and learn lessons in a way that has never been undertaken in the NHS.

Cumbria and the North East

2.36 Compared to the rest of the country, Cumbria and the North East have more individuals with a learning disability registered on GP registers and a higher usage of inpatient services (255 inpatient beds) mainly making use of two key hospital trusts – Northumberland, Tyne and Wear Foundation Trust and Tees Esk and Wear Valleys Foundation Trust.

2.37 These beds are a collection of secure and non-secure beds and are occupied not only by people from the area, but from across the country. Cumbria and North East aim to deliver a 52% reduction (76 beds) in non-secure beds and a 43% reduction (47 beds) in low secure beds. Commissioning action is already underway to facilitate this reduction, with 40 beds being empty at time of publication.

2.38 Building on service improvements in physical health, Cumbria and the North East are creating a single set of standards to incorporate into contracts used locally. Each local authority and CCG is developing and building community capacity, including in 2015/16 new investment in:

- Services to support people with attention deficit hyperactivity disorder and autism across Northumberland, and Tyne and Wear
- Advocacy services
- Carers support

2.39 Localities are also testing new approaches to improving quality. For example, in Newcastle an innovative housing initiative, developed through collaboration between social care providers and an NHS provider, is providing preventative care and treatment to improve the quality of support people with a learning disability and/or autism experience and to avoid unnecessary admissions.

2.40 A central plank to the plan is to retain staff to work in new models of care, and develop and up skill the workforce. For instance, working with Northumbria University and local clinicians they intend to implement a National Vocational Qualification (NVQ) based on PBS training for staff.

Hertfordshire

2.41 For several years Hertfordshire CCGs have been working with Hertfordshire Partnership Trust, Hertfordshire County Council and others to modernise services for people with a learning disability and/or autism, and they have already successfully closed many assessment and treatment beds across the area. But they believe they should go further.

2.42 Their ambition is now to bring adult and children's services together into a dedicated integrated service. This will include a single point of access that will empower service users of all ages to access help, support and appropriate treatment in the community. This model will be consulted on before the end of the year.

2.43 By 2018/19 they expect to reduce their usage of low-secure beds by over 30%, and to reduce length of stay in assessment and treatment beds to an average of 85 days.

2.44 Furthermore, they are establishing an evaluation partnership with Hertfordshire University to test a number of prevention and early discharge services for individuals who have been in contact with the criminal justice system. This includes a strengthened community forensic team to enable faster supported discharge and greater use of community restriction orders, and a Circles Project to deliver community support to people with a learning disability and/or autism who are deemed to be at high risk of sexual offending.

2.45 Recognising that individuals' needs can increase, a number of innovative crisis intervention pilots will be commissioned and evaluated from 2015/16, namely:

- A hosted family crisis support pilot which will provide intensive home support during crisis periods
- A 'crash pad' pilot providing short term accommodation for people who need crisis intervention in situations where there has been a placement breakdown or termination of tenancy

2.46 Finally, Hertfordshire has already begun work to pilot the implementation of integrated personal health budgets, which will start to be introduced from April 2016.

Nottinghamshire

2.47 Nottinghamshire intends to reduce its reliance on non-secure services from 40 occupied beds to 15 (a 63% reduction) and almost halve its usage of low and medium secure beds from 34 to 16 (a 56% reduction). Nottinghamshire now has 65 people in inpatient care in NHS trusts and the independent sector.

2.48 Nottinghamshire's plan has individual rights at its centre and an immediate priority is to commission an increase in advocacy for people during care and treatment reviews. Early plans also include strengthening their existing community learning disability and intensive care and treatment teams, as well as risk registers, so they can confidently support individuals who are at risk of coming into contact with the criminal justice system and subsequent admission to hospital.

2.49 Recognising that confidence of staff and families is paramount to helping individuals stay at home, families will be offered evidence-based parenting training as well as practical and emotional support locally. In addition, to retain and up skill staff to deliver the new care model workforce training will be undertaken to ensure staff have a consistent understanding and approach to working with people who display behaviour that challenges which enables individuals to remain in the least restrictive setting.

2.50 Next year, they will expand their personal health budget offer and tackle gaps in the accessibility of mainstream services. As the needs of individuals can increase, new crisis accommodation will be established as well as new pioneering housing options for people with complex behaviours and those in contact with the criminal justice system as they are discharged from hospital.

2.51 Nottinghamshire will start to pool budgets for crisis care from April 2016 and work towards further alignment and pooling arrangements from April 2017.

2.52 Finally, across Nottinghamshire there are a high number of local inpatient beds (199), many of which are not used by local commissioners. The Fast Track has recognised that the longer term plan of this economy will require strong partnerships with other commissioners across the country.

Arden, Herefordshire and Worcestershire

2.53 Commissioners in Arden, Herefordshire and Worcestershire have been driving forward improvements in learning disabilities for several years and have agreed strategies for improving both physical and mental health and been steadily reducing reliance on hospital beds. They now have 47 people in inpatient care, mainly in Coventry and Warwickshire NHS Trust.

2.54 It is expected that across the area they will reduce the number of beds used by inpatients to 14. This means reducing their usage of non-secure beds from 19 to 3 (an 85% reduction), and of secure beds from 21 to 11 (a 48% reduction). They also intend to reduce their usage of child and adolescent mental health service (CAMHS) beds by children with a learning disability and/or autism by seven.

2.55 These closures are expected to start this year, with a nine-bed assessment and treatment ward shutting (subject to appropriate local consultation).

2.56 Their intention is to redeploy staff working in that unit to new community services, and having learnt from the experience and undertaken appropriate consultation, to apply the learning to other sites.

2.57 In addition, the area plans to develop by November 2015:

- An admission avoidance scheme in Coventry and Warwickshire NHS Trust
- A short-term accommodation for people who need support when a placement breaks down or, for example, if a tenancy breaks down

2.58 Throughout the rest of the year, across Arden, Herefordshire and Worcestershire the aim is to create intensive community support teams which will work with existing mental health crisis teams to provide comprehensive crisis care 24/7. To facilitate this they plan to have a liaison nurse who will work to improve support and the interface between learning disability and wider mental health services.

2.59 From April 2016 a community forensic service will be commissioned to support people to be discharged who are currently out of area and enhance the support locally to avoid future admissions. The aim is to then review the coverage and plan for further closures in 2017/18.

2.60 Finally, Coventry and Warwick Partnership Trust are commissioned by other West Midlands commissioners. The Arden, Hereford and Worcestershire Fast Track is exploring strategic alliances with them to spread learning and support change.

Figure 5: Projected bed usage rates across fast track sites (inpatients per million population)[10]

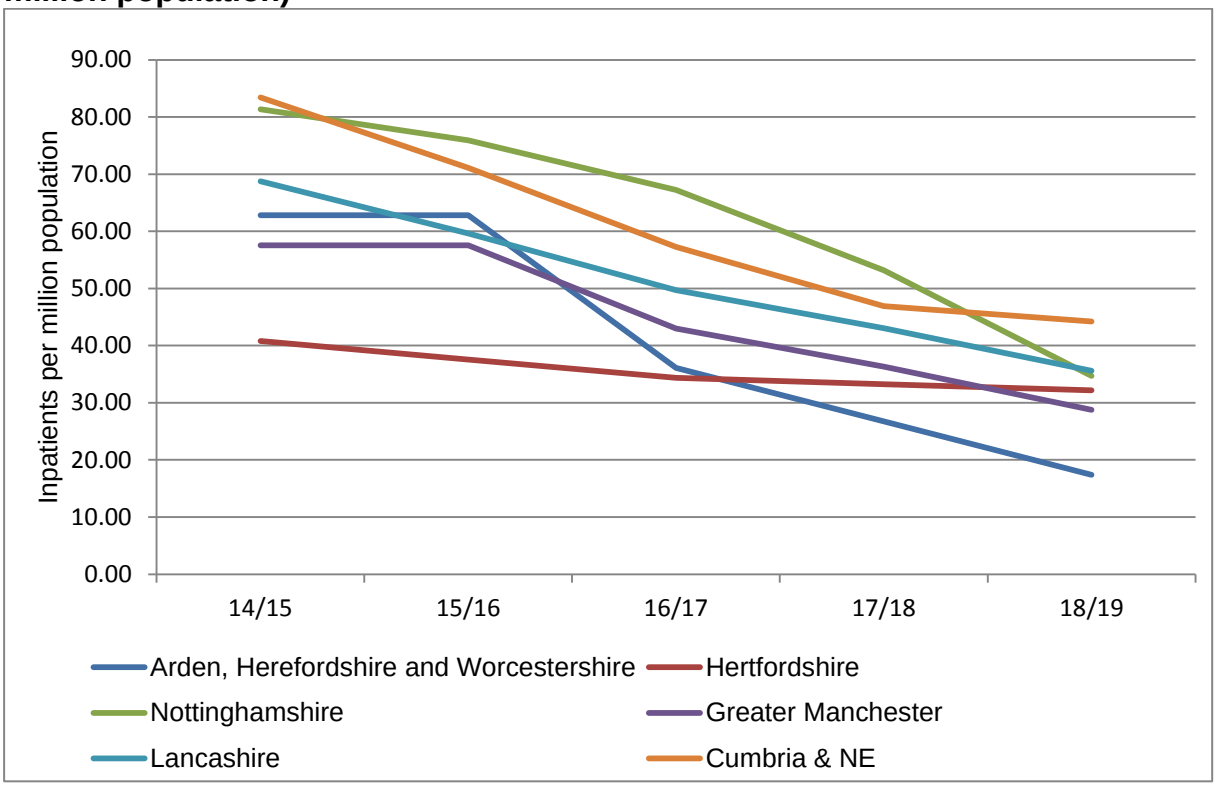
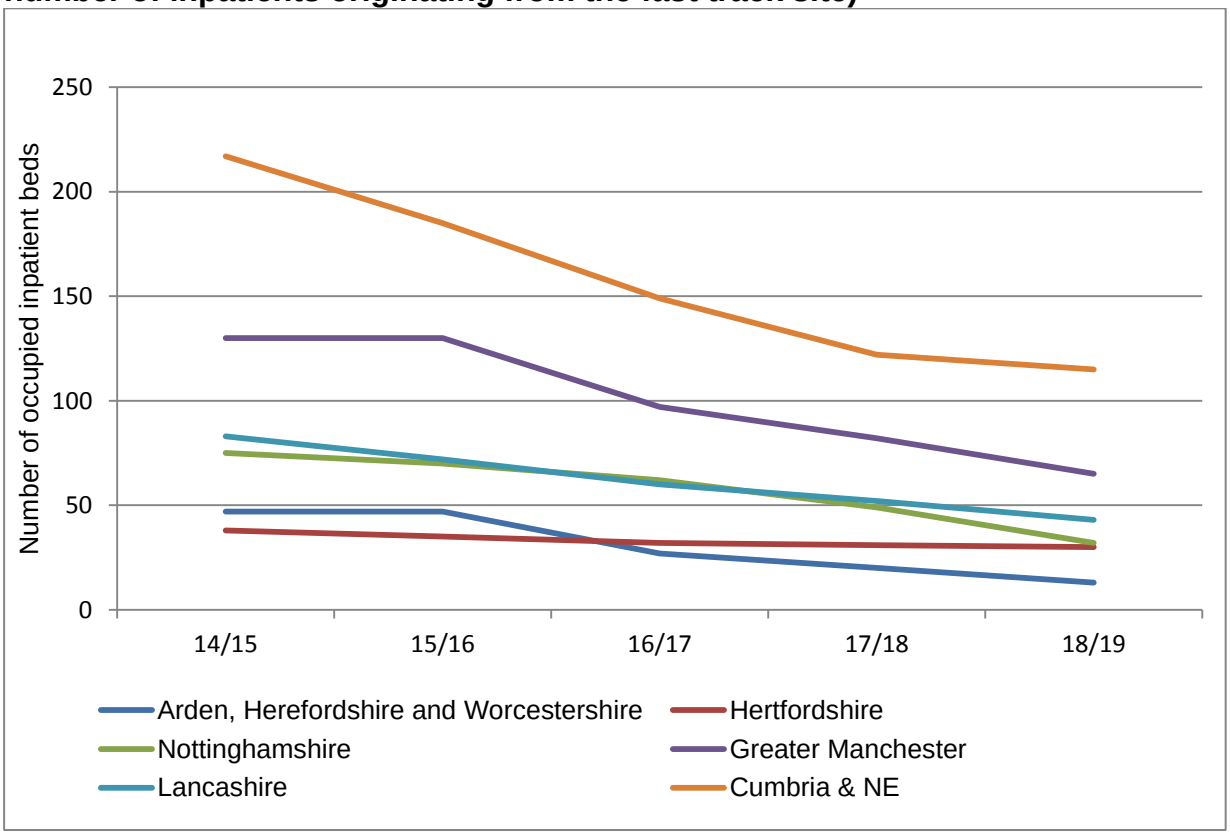


Figure 6: Projected *total* bed usage across fast tracks (chart shows projected number of inpatients originating from the fast track site)[11]



[10] See Annex C for further notes on the data used in these charts
[11] See Annex C for further notes on the data used in these charts

Figure 7: Projected usage of *NHS England*-commissioned beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[12]

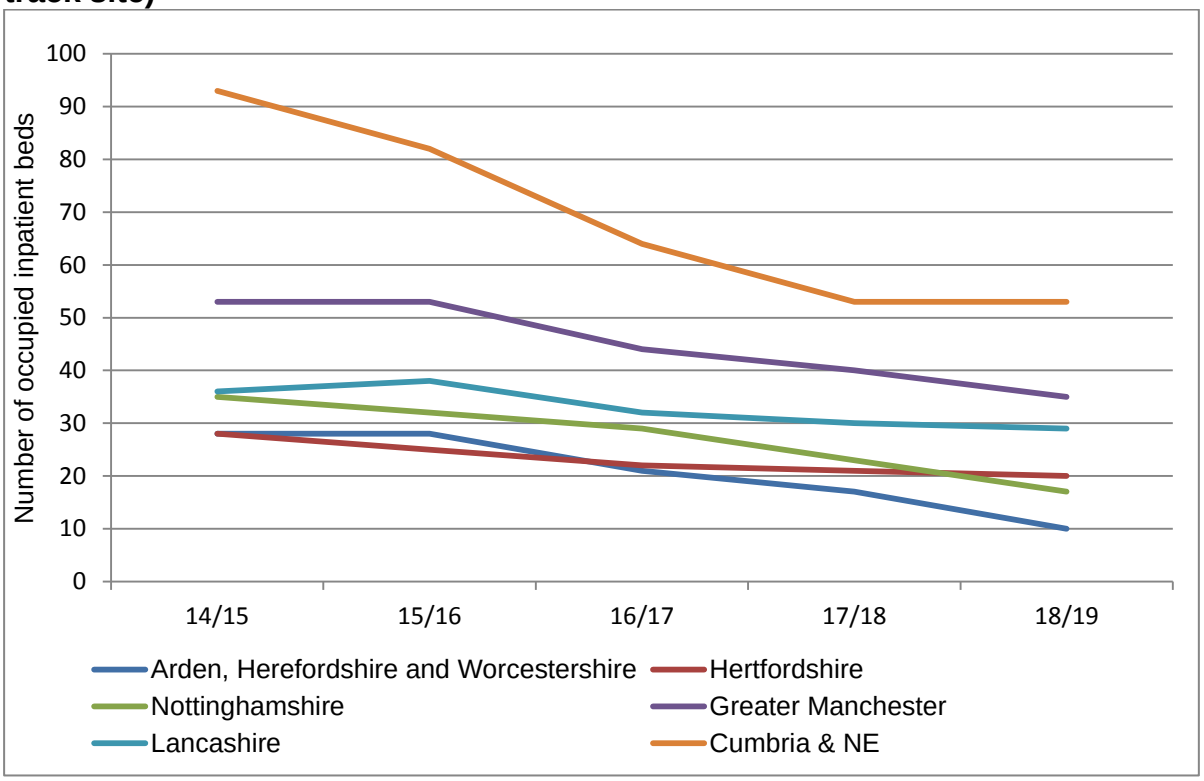
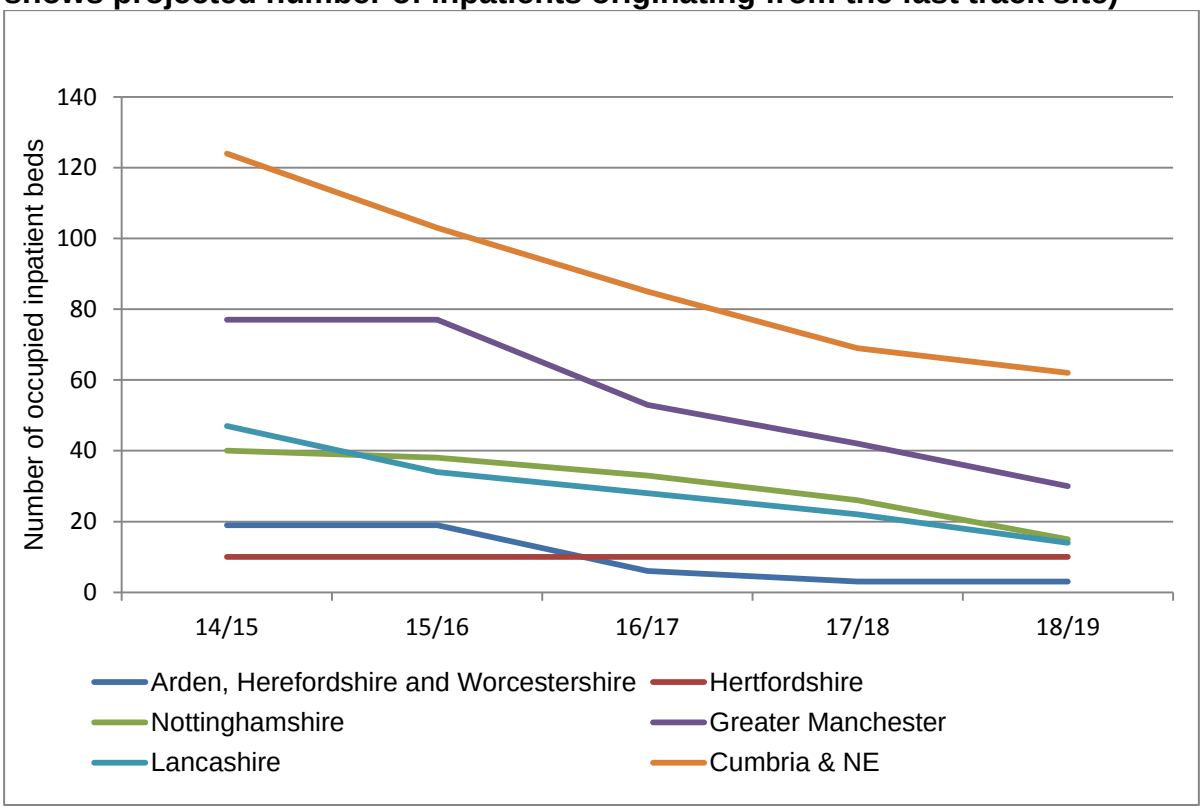


Figure 8: Projected usage of *CCG-commissioned* beds across fast tracks (chart shows projected number of inpatients originating from the fast track site)[13]



[12] See Annex C for further notes on the data used in these charts
[13] See Annex C for further notes on the data used in these charts

2.61 The action outlined above represent just the start of what the fast tracks will do, and as their plans develop and community services mature we expect the bed reduction trajectories set out in their plans to translate into further closure of individual wards and units. As the fast track areas start to implement their ambitious plans for change, NHS England, LGA and ADASS will draw on our experience of working with them to support the rest of the country to build new community services and close inpatient provision that is no longer needed. The rest of this plan sets out how these new services should look, and how we plan to work together to deliver them.

3. The new services we need

3.1 People with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with dignity and respect. They should expect, as people without a learning disability or autism expect, to live in their own homes, to develop and maintain positive relationships and to get the support they need to be healthy, safe and an active part of society.

3.2 As Professor Jim Mansell highlighted in 1993 and in 2007, however, too rarely do people receive this type of personalised support across their whole life. In turn, many of the behaviours services label as challenging could be prevented from developing if the right support were made available to people and their families or carers when they needed it.

3.3 The changes to services we plan to make are intended to put that right.

Improving services for a heterogeneous group

3.4 People with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. The task of reshaping services will reflect that diversity.

3.5 For people who have been in inpatient settings for a very long period of time, the task facing commissioners will be to resettle those individuals into the community and close the hospital beds behind them. This will include a number of people who will have been in hospital for many years, in some cases having not been discharged when NHS campuses or long-stay hospitals were closed. It is the group of people for whom hospital has effectively become a permanent home, and for whom the task now is to find them a more appropriate home in the community, with the right package of health and care support around them. This is the group who will likely be eligible for NHS-funded dowries when they are ready to be discharged, to help fund their new package of care in the community (see chapter 4 for more detail on how these ‘dowries’ will work).

3.6 Approximately a third of the people currently in hospital have been in inpatient settings for five years or longer. Whilst hospital may be the right place for some of this group (for clinical reasons often combined with Ministry of Justice restrictions), Care and Treatment Reviews have already identified transfer/discharge dates over the coming three years for just under 40% of the individuals concerned, and we would expect that number to rise as we build the right set of services in the community.

3.7 In the main, however, the challenge facing commissioners is as much about preventing new admissions and reducing the time people spend in inpatient care by providing alternative care and support, as it is about discharging those individuals currently in hospital. The task requires: advocacy, early intervention, prevention, ensuring the right set of services are available in the community.

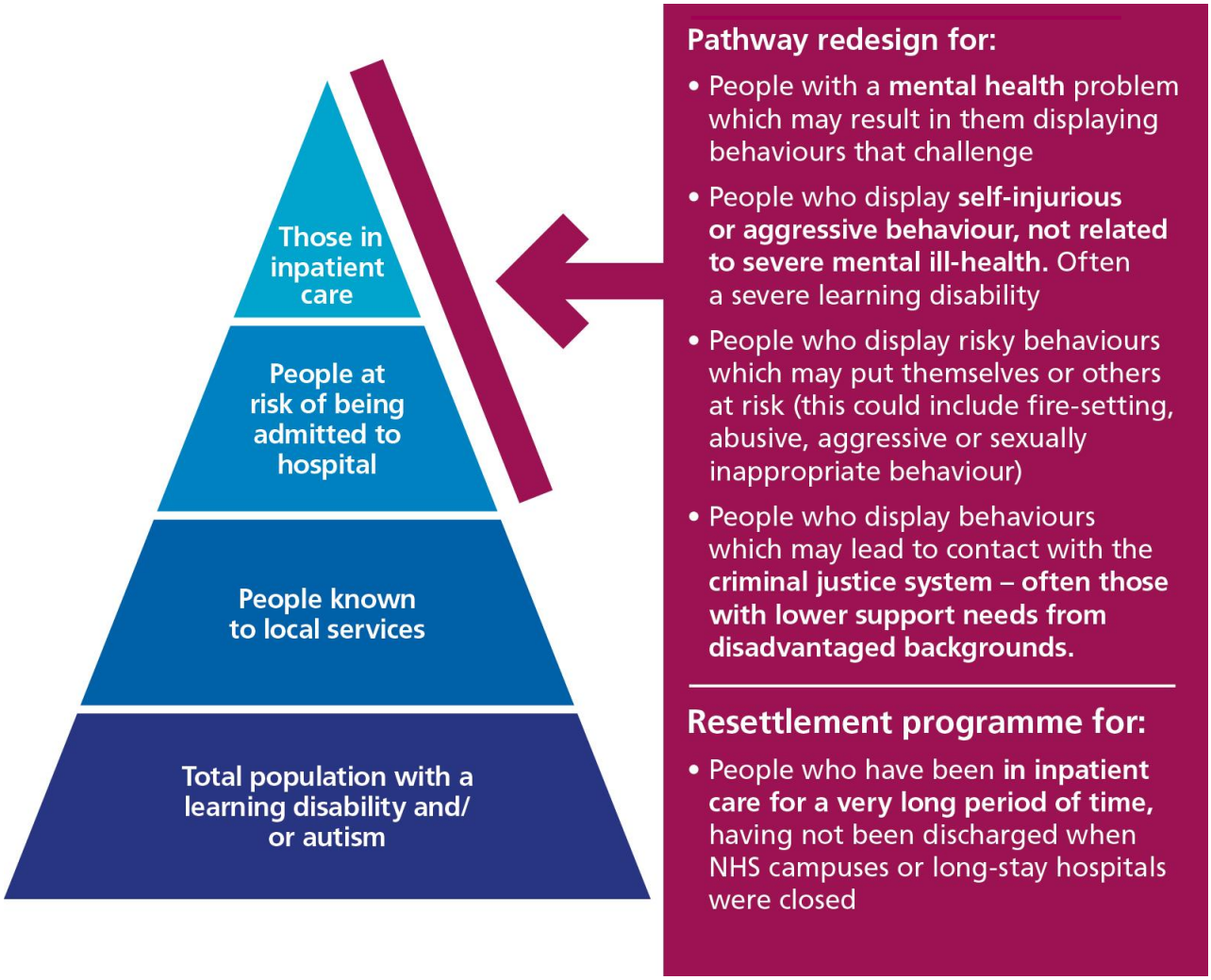
3.8 In many cases, it will involve close collaboration not just between the NHS and social care, but also with parts of the criminal justice system, building on recent joint work between NHS England and the Ministry of Justice to facilitate discharges of patients subject to restriction orders - currently more than one in five of the people in hospital settings have been detained on part III of the Mental Health Act with a Ministry of Justice restriction.

3.9 Transformation will mean redesigning services to better meet a range of common sets of needs. For instance, it will mean better serving children, young people or adults with a learning disability and/or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neuro-developmental syndrome where there may be an increased likelihood of developing behaviour that challenges
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour)
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system

3.10 The different kinds of shift in service response required to better meet these different needs are set out in more detail in a national service model for commissioners of health and social care services, developed with the support of a group of independent experts, including people with lived experience of services, and published alongside this document.

Figure 9: People for whom we need new services



The service model

3.11 Each local area is different. Local populations have different needs, and their range of providers have different strengths and weaknesses. The mix of services they put in place will need to reflect that diversity. However, there does need to be some national consistency in what services look like across local areas, based on established best practice.

3.12 The national service model, developed with the support of people with learning disability and/or autism, as well as families/carers, and a group of independent experts and published alongside this document, sets out how services should support people with a learning disability and/or autism who display behaviour that challenges.

The National Service Model

1. People should be supported to have a **good and meaningful everyday life** - through access to activities and services such as early years services, education, employment, social and sports/leisure; and support to develop and maintain good relationships.

2. Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

3. People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

4. People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

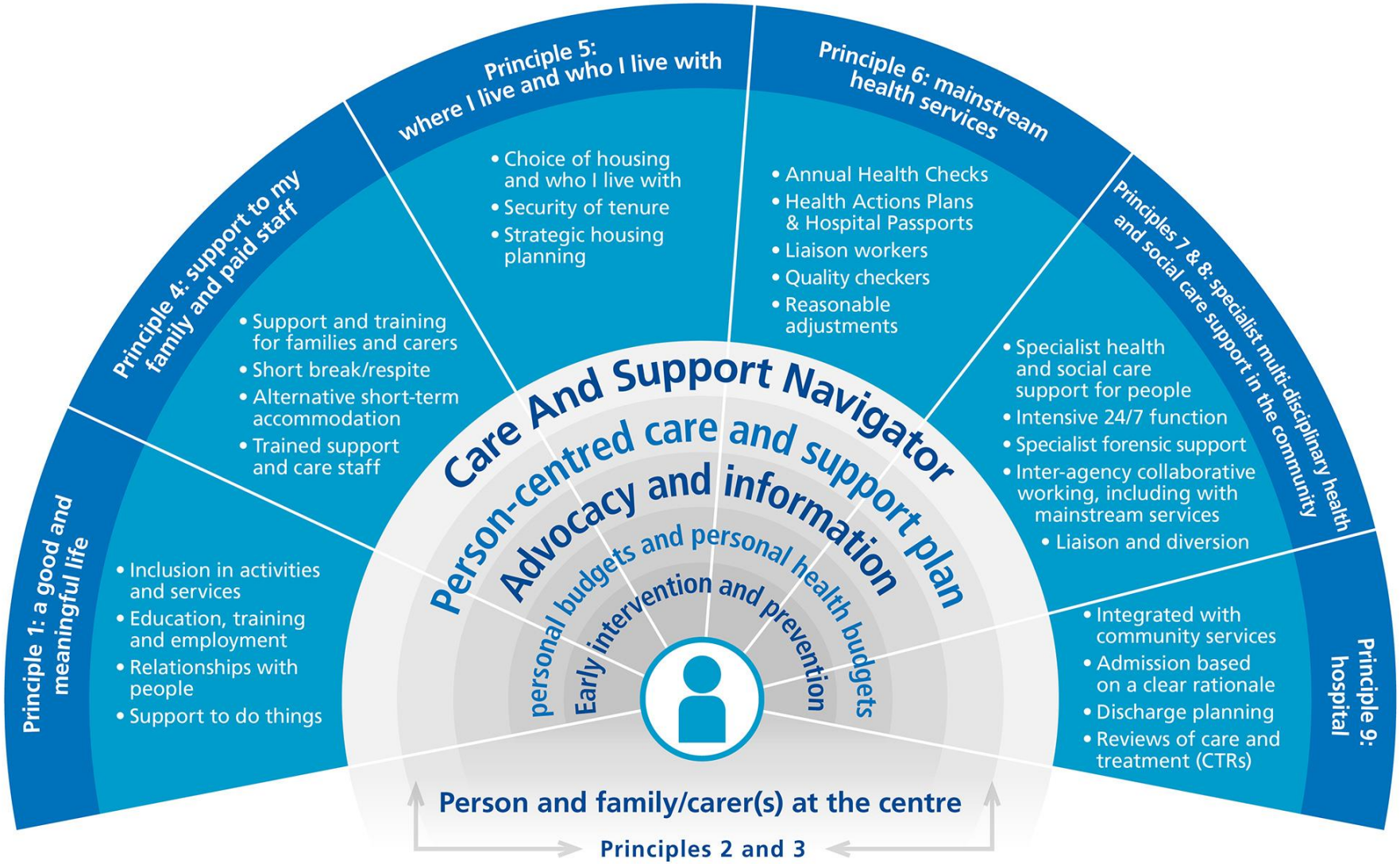
5. People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation.

6. People should get good care and support from **mainstream NHS services,** using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).

7. People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

8. When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or ‘offending’ behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk to others in the community.

9. When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a **hospital** setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.



Service Model

Commissioners understand their local population now and in the future

Reduced need for inpatient services

3.13 With the right set of services in place in the community, the need for inpatient care will significantly reduce, and commissioners will need to have in place far less hospital capacity.

3.14 We will support local commissioners to plan exactly what inpatient capacity they do need, starting with a set of national planning assumptions. Those planning assumptions are that by March 2019, no area should need more inpatient capacity than is necessary at any one time to cater to:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

3.15 In some local areas, use of beds will be lower than these planning assumptions, and we will encourage those local areas to see if they can go still further in supporting people out of hospital settings above and beyond the these initial planning assumptions.

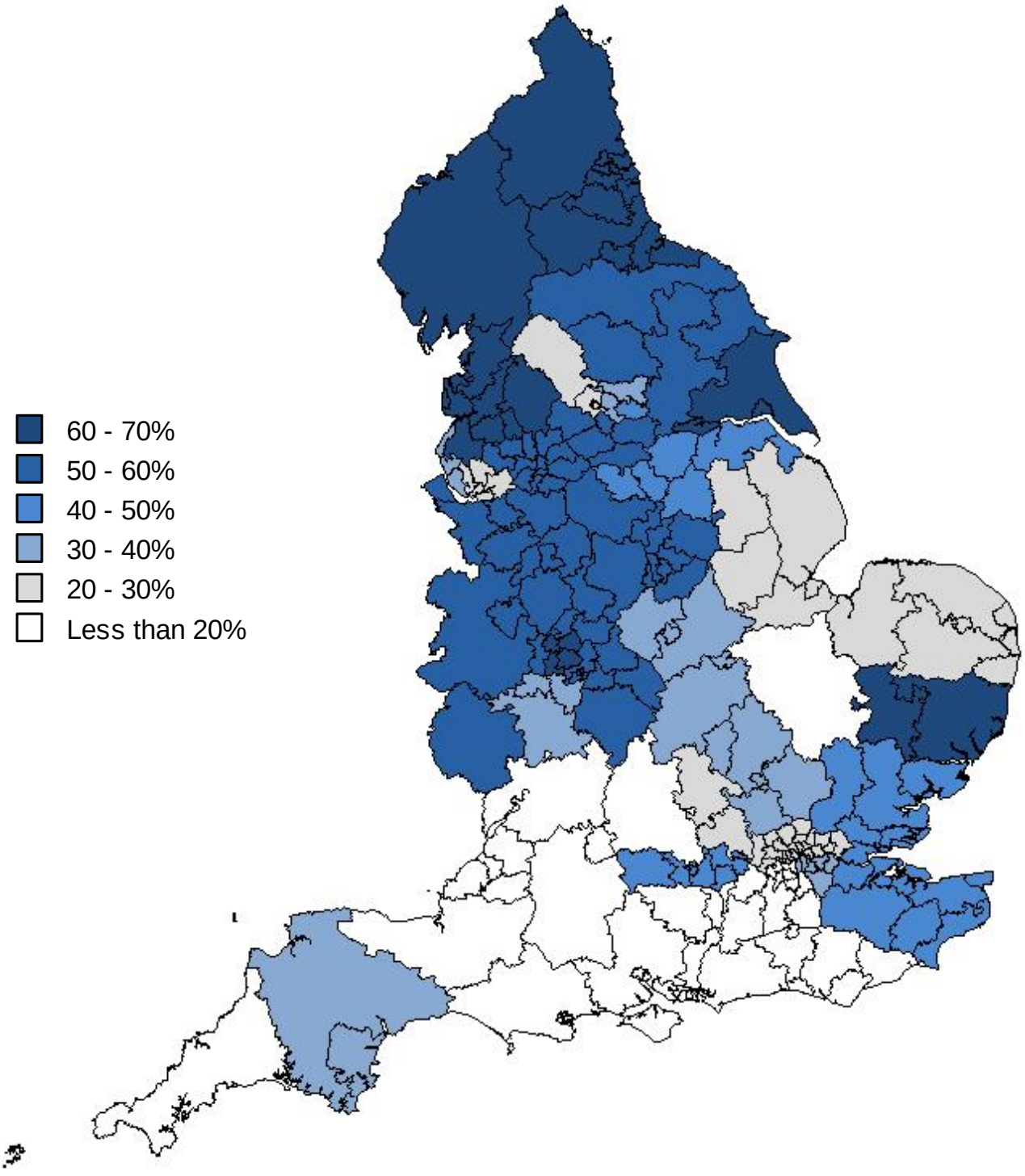
3.16 These planning assumptions are based on what fast track areas have told us they believe is possible, 'sense-checked' against current geographical variation in usage of inpatient services (see figures 2 and 3 below).

3.17 These planning assumptions (10-15 inpatients in CCG-commissioned beds per million population; 20-25 inpatients in NHS England-commissioned beds per million population) would translate to closing, at a minimum:

- 45-65% of CCG-commissioned inpatient capacity (such as assessment and treatment units)
- 25-40% of NHS-England- commissioned inpatient capacity (such as secure services, where we expect the bulk of change to occur in low-secure provision)

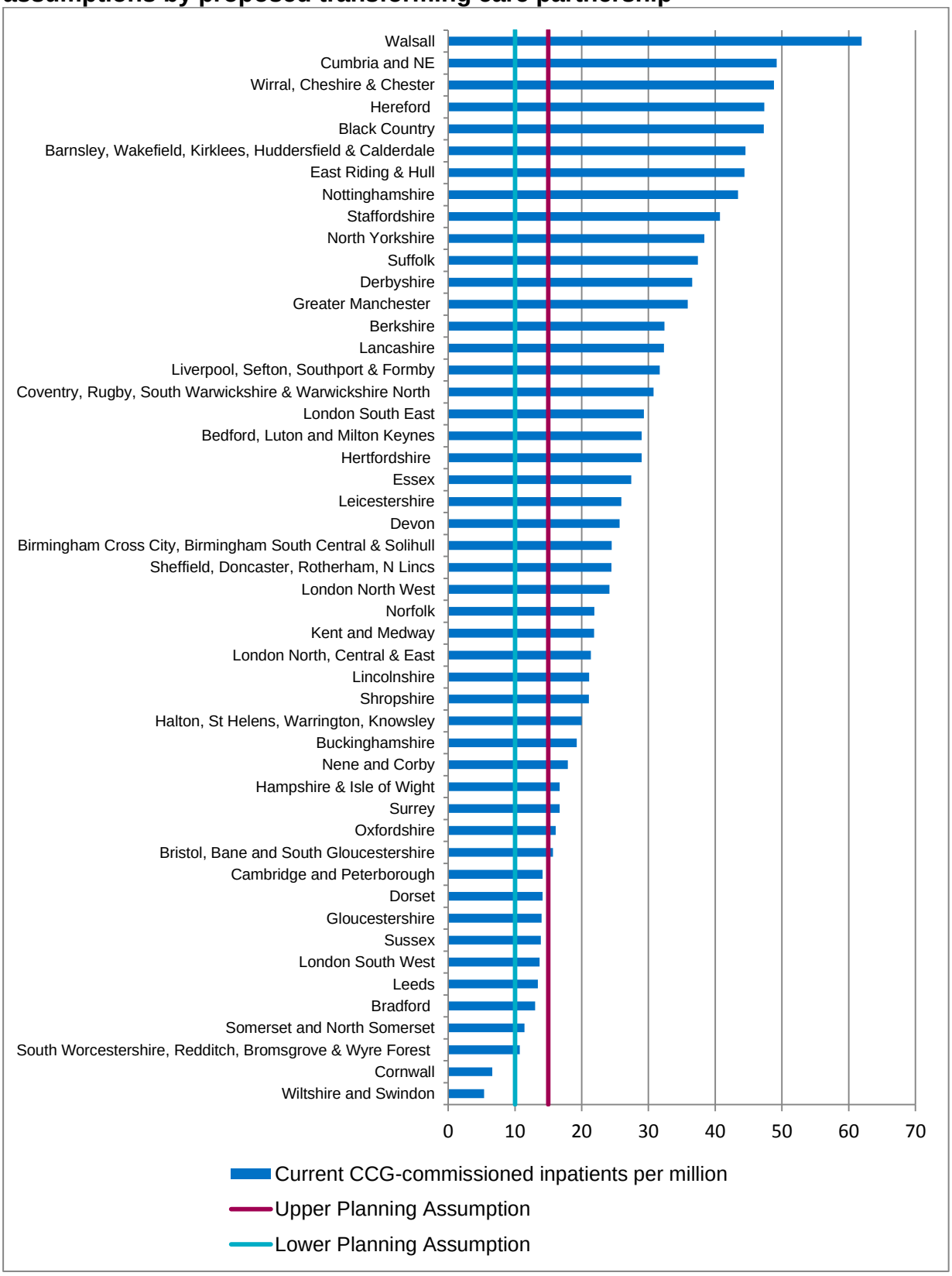
3.18 Taken together, that means closing, at a minimum, between 35% - 50% of inpatient provision nationally. In some areas more reliant on hospital care the change will be even more significant, as the following map and charts illustrate.

Figure 10: Reduction in bed usage (%) implied by national planning assumptions, by proposed transforming care partnerships[14]



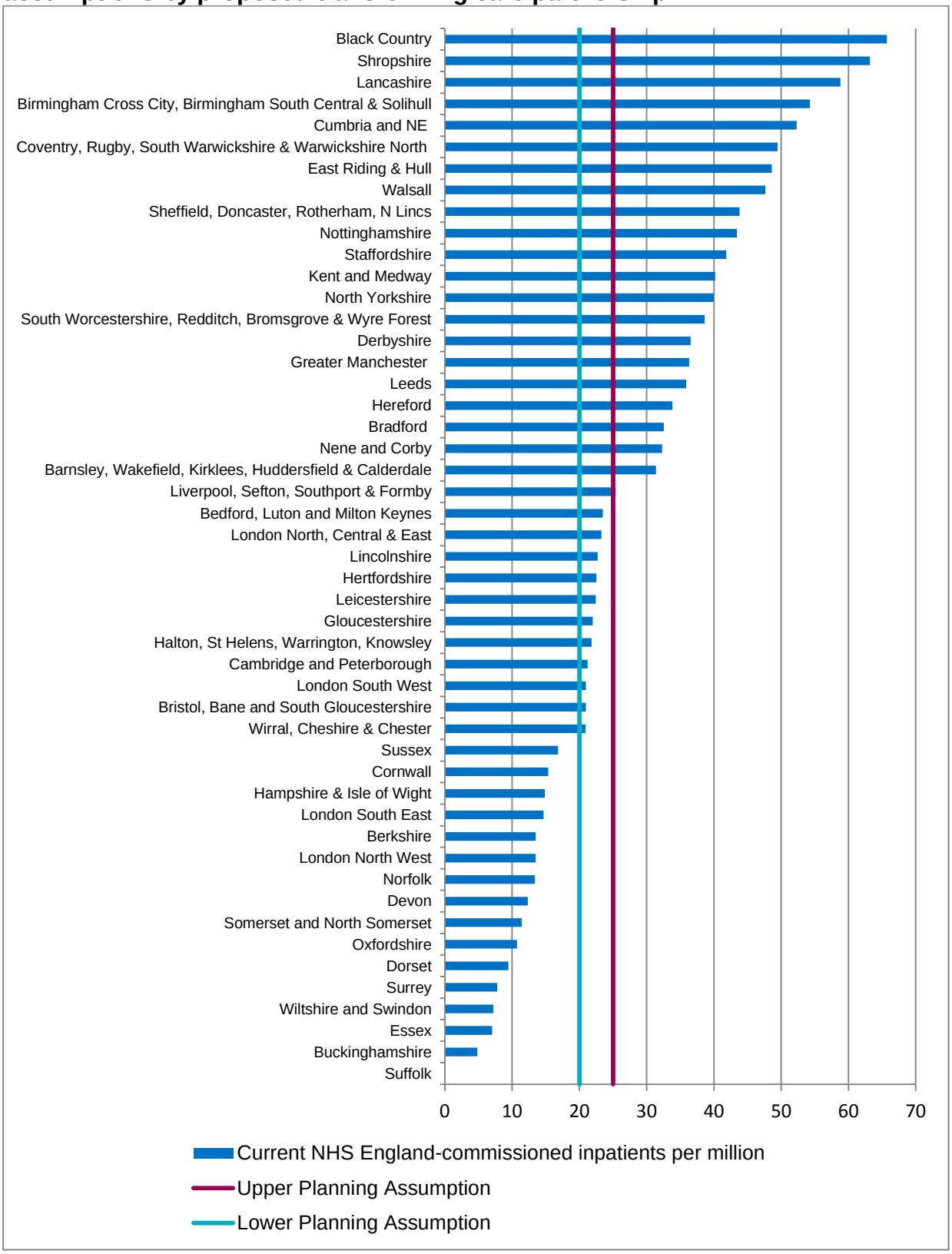
[14] Upper and lower planning assumptions have been applied to current inpatient rates at a transforming care partnership level. The map shows the % reduction in inpatient numbers represented by the midpoint between the projected upper and lower rates for each partnership. See Annex C for further notes on the data used in these charts

Figure 11: Geographical variation in reliance on *CCG-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[15]



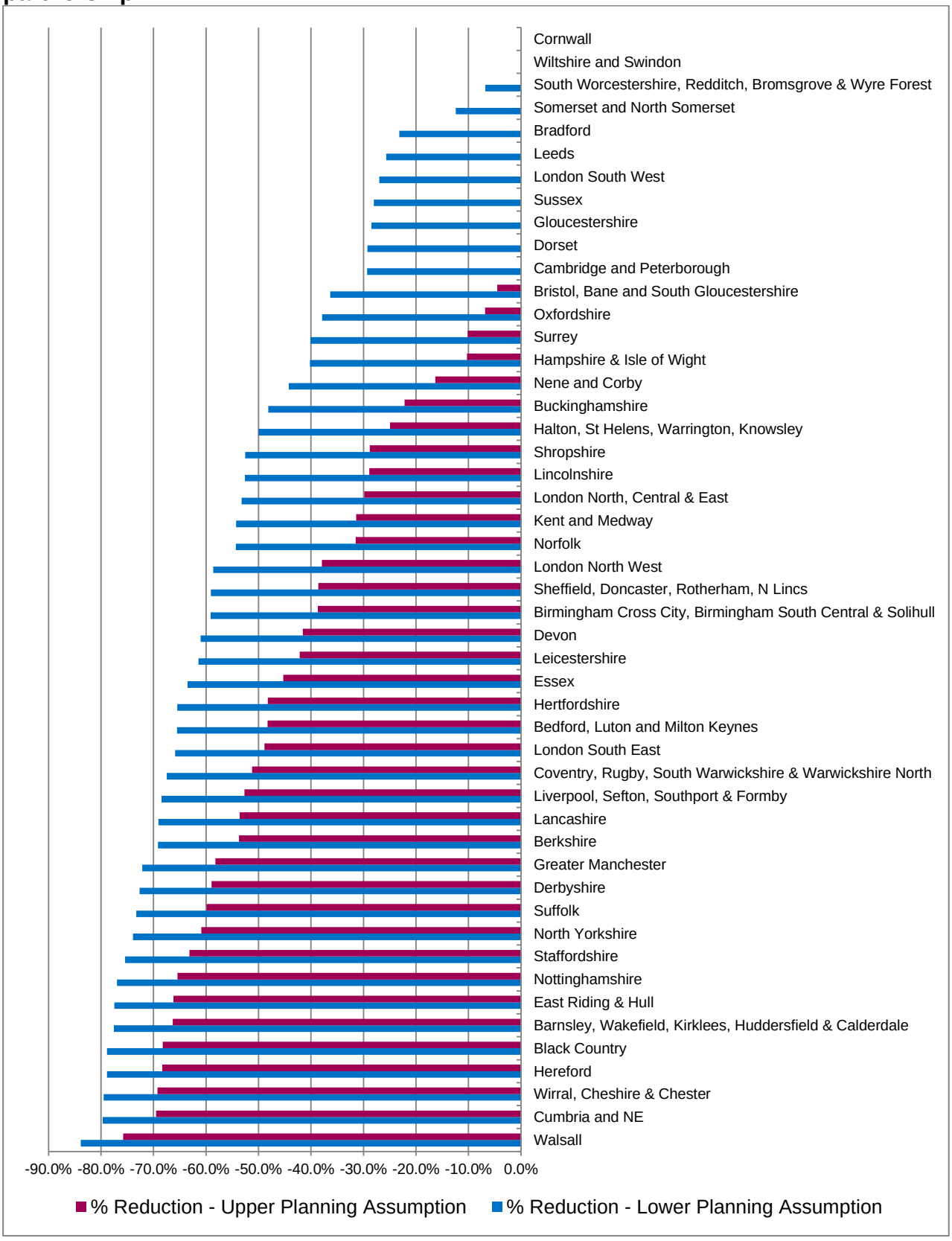
[15] See Annex C for further notes on the data used in these charts

Figure 12: Geographical variation in reliance on *NHS England-commissioned* inpatient services (as at 31 July 2015), shown against new national planning assumptions by proposed transforming care partnership[16]



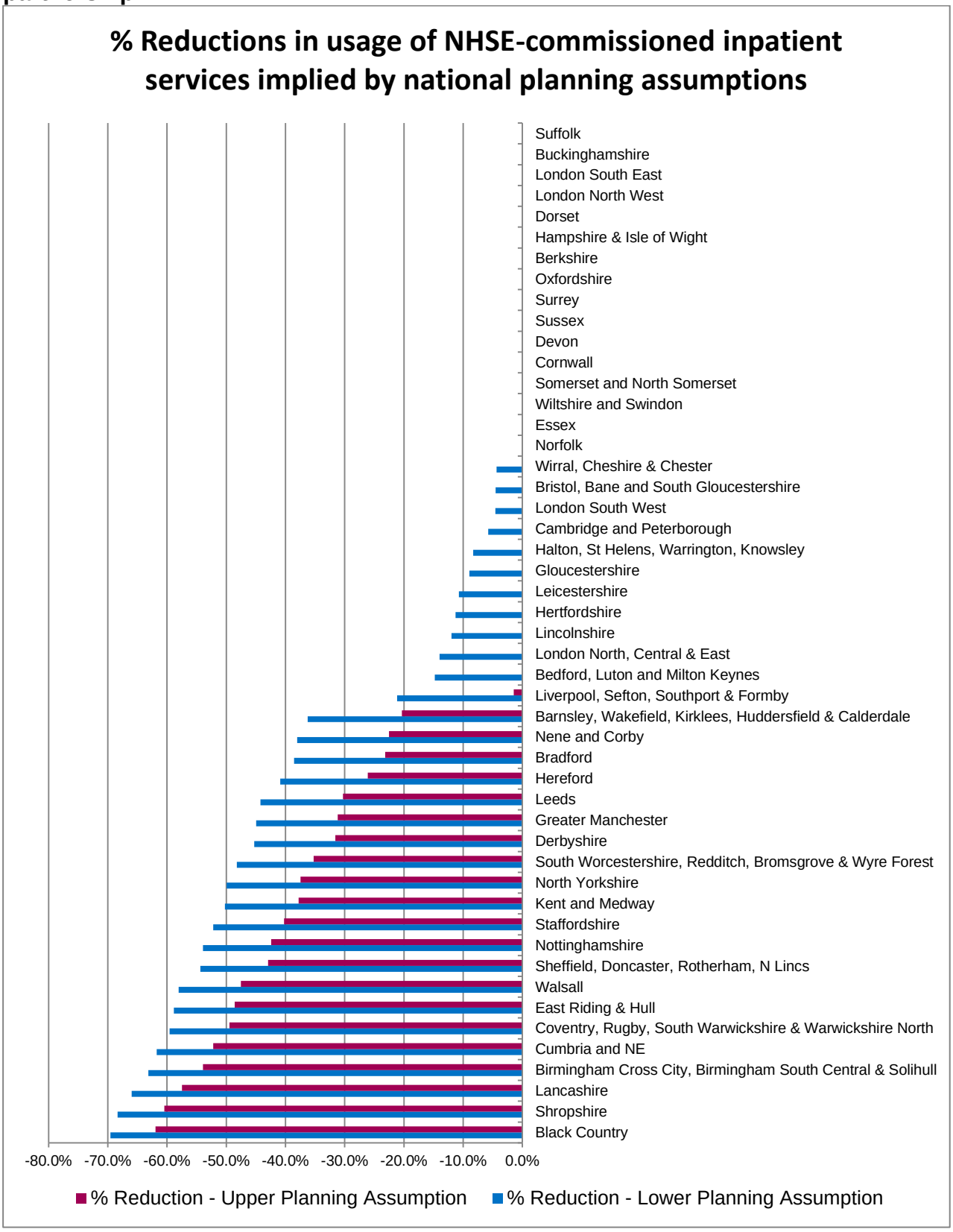
[16] See Annex C for further notes on the data used in these charts

Figure 13: Reductions in usage (%) of *CCG-commissioned* inpatient services implied by national planning assumptions by proposed transforming care partnership[17]



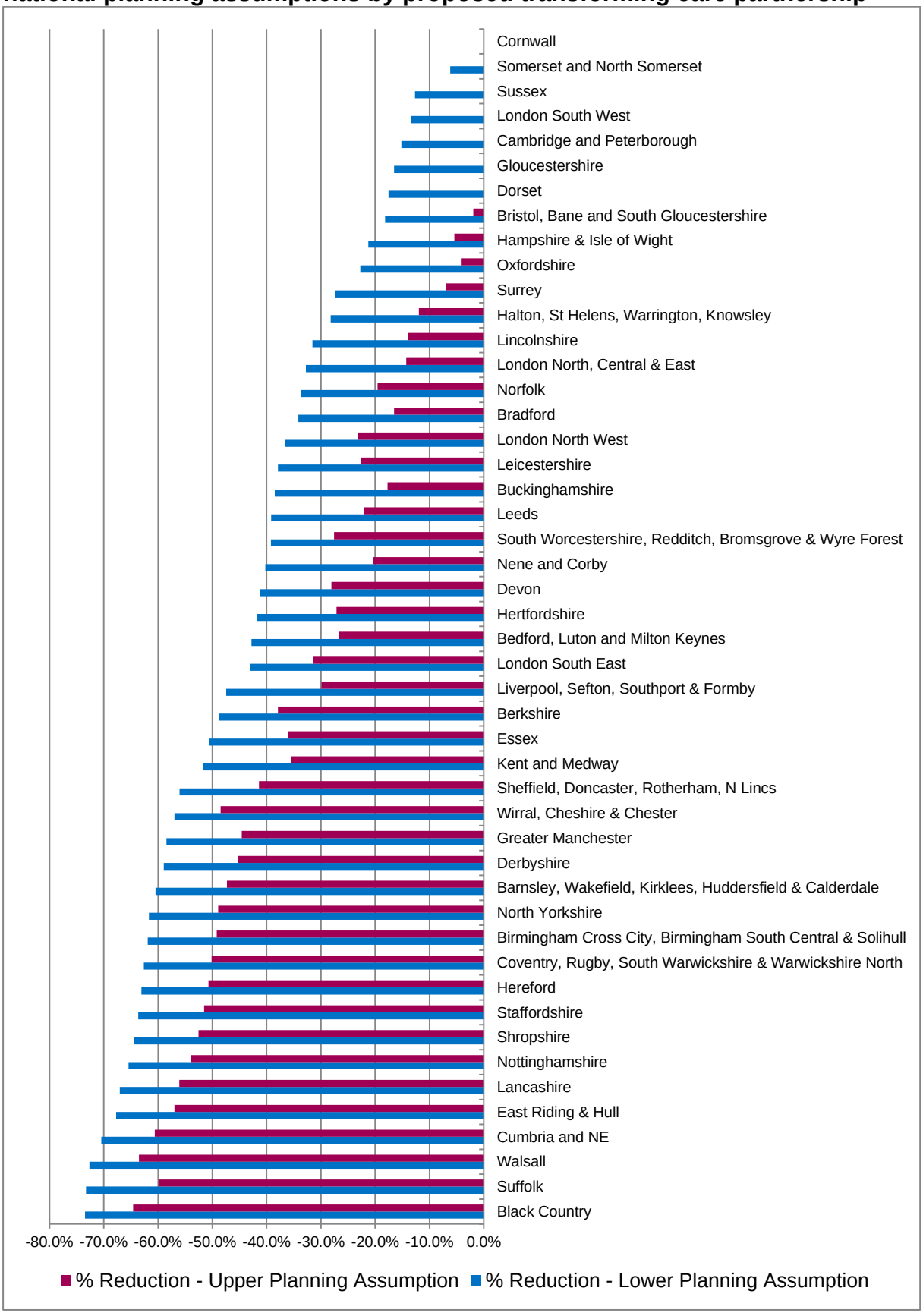
[17] See Annex C for further notes on the data used in these charts

Figure 14: Reductions in usage (%) of *NHS England-commissioned* inpatient services implied by national planning assumptions by transforming care partnership[18]



[18] See Annex C for further notes on the data used in these charts

Figure 15: Reductions in *total* usage (%) of inpatient services implied by national planning assumptions by proposed transforming care partnership[19]



[19] See Annex C for further notes on the data used in these charts

3.19 These national planning assumptions should be seen as articulating a minimum ambition for the coming three years - not a target that, once met, renders the task complete.

3.20 These assumptions are exactly what the term implies – assumptions for local commissioners to use as they enter into a detailed process of planning. Local planning needs to be creative and ambitious based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. The starting point for service planning should be to think creatively about what support would help people to live the best possible life, as opposed to making marginal change to the set of services we have currently – and we will support people with lived experience, clinicians, providers and other experts to work with commissioners and help them think ambitiously and creatively in that way.

3.21 In parallel to these planning assumptions, for the inpatient provision that remains we will work with clinicians, providers and commissioners to reduce the period of time that people spend in hospital, building on and spreading best practice – for instance, Hertfordshire's fast track plan aims to help reduce length of stay in assessment and treatment services to an average of 85 days. We will also use Care and Treatment Reviews (CTRs) to this end: if someone is still in hospital after six months a mandatory CTR will take place, and people in hospital will also have a right to request a CTR.

3.22 The planning assumptions articulated here should not be seen as describing an 'end state' after which services can be set in aspic. We will always want to improve the services and support we make available to people with a learning disability and/or autism. So before the end of 2018, having built up community support and closed hundreds of beds, we will take stock and look at going further with the development of community support and the closure of inpatient services.

3.23 The immediate task now, however, is to start delivering the ambitious changes set out above. What follows is our plan for doing that.

4. Working together to provide new services

Transforming care partnerships

4.1 To deliver the change outlined in the previous chapter, and following what we have learned from the fast tracks, NHS commissioners, in discussion with local government, are mobilising transforming care partnerships – collaborations of CCGs, local authorities and NHS England specialised commissioners.

4.2 Currently the approach to commissioning services for people with a learning disability and/or autism is fractured, with responsibility split between local authorities, CCGs and NHS England. It can be difficult to move funding from one agency to another, to enable the commissioning of less inpatient care and more preventative, community-based services and support. Furthermore, many CCGs will be commissioning for a small number of people with a learning disability and/or autism, making it difficult to take a strategic approach to changing services across the system. Hospitals caring for this group of patients will often be commissioned by a large number of CCGs and NHS England, so that it is difficult for one commissioner to work with those providers to change the services they offer.

4.3 The new transforming care partnerships, currently mobilising, are intended to help address these weaknesses in commissioning arrangements. They will bring together the commissioners responsible for funding health and social care for people with a learning disability and/or autism (CCGs, local authorities with their responsibilities for care and housing, NHS England specialised commissioning), with their budgets aligned or pooled as appropriate. Figure 16 below and Annex A set out further details on how CCGs propose to cluster together in order to work with local authorities and NHS England specialised commissioning hubs in these new partnerships. We expect all CCGs in England to have finished these arrangements by December 2015.

4.4 Transforming care partnerships will be supported to work alongside people who have experience using these services, as well as their families/carers, clinicians, providers and other stakeholders to formulate and implement **joint transformation plans** – closing some inpatient provision and shifting investment into support in the community.

4.5 They will bring commissioners together at a scale larger than most CCGs and many local authorities, with their geographical footprint based on:

- Building where possible on existing collaborative commissioning arrangements (e.g. joint purchasing arrangements amongst CCGs, joint commissioning arrangements between CCGs and local authorities)
- Local health economies of services for people with a learning disability and/or autism (e.g. patient flows, the provider landscape, and relationships between commissioners and providers). Where, for instance, a number of CCGs tend to use the same hospital provider for inpatient services for

people with a learning disability and/or autism, it makes sense for those CCGs to implement change collaboratively
- Commissioning at sufficient scale to manage risk, develop commissioning expertise and commission strategically for a relatively small number of individuals whose packages of care can be very expensive

The challenge

4.6 Each Transforming Care Partnership will be supported to improve outcomes for people with a learning disability and/or autism – both those currently in inpatient services (of whom there are approximately 2,600 nationally) and those in the community at risk of being admitted to hospital without the right support (of whom there are an estimated 24,000 nationally[20]).

4.7 We will support local transforming care partnerships to make progress on three outcomes:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.8 People with a learning disability and/or autism as well as their families/carers should be supported to co-produce these plans. The change we need to see is as much about a shift in power as it is about service reconfiguration, and that should be reflected not just in the new services and support put in place (where for instance the national service model calls for the expansion of personal health budgets and high-quality independent advocacy), but in the way service changes are planned and delivered.

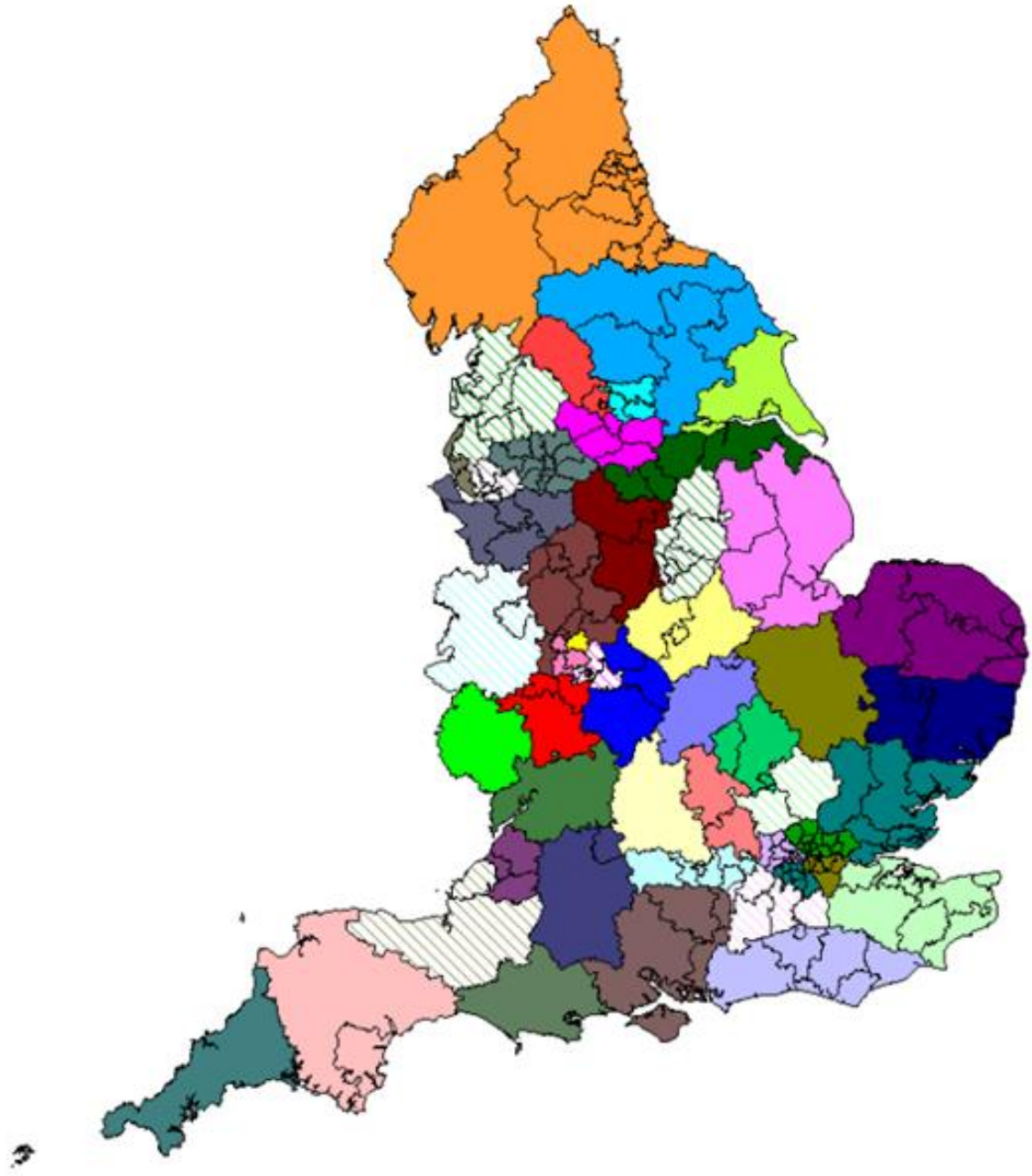
4.9 We will expect transforming care partnerships to tailor their approach based on local context, but in a way that is consistent with national parameters - in particular, the national service model and minimum planning assumptions on inpatient capacity outlined in chapter 3.

4.10 This work will also need to align with a number of other national priorities, such as:

- Local Transformation Plans for Children and Young People's Health and Wellbeing
- Local action plans under the Mental Health Crisis Concordat
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)
- Work to implement the Autism Act 2009 and recently refreshed statutory guidance
- The roll out of education, health and care plans

[20] K. Lowe et al, Challenging Behaviours: prevalence and topographies. Journal of Intellectual Disability Research, 51, 625–636 (2007).

Figure 16 – Proposed transforming care partnerships



Transforming Care Partnerships

- South Worcestershire, Redditch, Bromsgrove & Wyre Forest (Fast Track)
- Hereford (Fast Track)
- Coventry, Rugby, South Warwickshire & Warwickshire North (Fast Track)
- Birmingham Cross City, Birmingham South Central & Solihull
- Walsall
- Black Country
- Derbyshire
- Nottinghamshire (Fast Track)
- Suffolk
- Norfolk
- Cambridge and Peterborough
- Essex
- Bedford, Luton and Milton Keynes
- Hertfordshire (Fast Track)
- Nene and Corby
- Lincolnshire
- Leicestershire
- Shropshire
- Staffordshire
- Gloucestershire
- Wiltshire and Swindon
- Bristol, Bane and South Gloucestershire
- Somerset and North Somerset
- Cornwall
- Devon
- Kent and Medway
- Sussex
- Surrey
- Oxfordshire
- Buckinghamshire
- Berkshire
- Hampshire & Isle of Wight
- Dorset
- Wirral, Cheshire & Chester
- Halton, St Helens, Warrington, Knowsley
- Liverpool, Sefton, Southport & Formby
- Greater Manchester (Fast Track)
- Lancashire (Fast Track)
- Cumbria and NE (Fast Track)
- North Yorkshire
- Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale
- Bradford
- Leeds
- Sheffield, Doncaster, Rotherham, N Lincs
- East Riding & Hull
- London North West
- London North, Central & East
- London South East
- London South West

Supporting local areas

4.11 NHS England, LGA and ADASS will support transforming care partnerships through the different stages of their journey in planning for and implementing change.

Mobilisation

4.12 Local areas will need to have a solid foundation upon which to base transformation, including strong leadership and sound governance, engagement and commitment to joint working amongst a complex range of stakeholders.

4.13 As with the fast track areas, we envisage all transforming care partnerships having a single Senior Responsible Officer (SRO) responsible for the development and delivery of this work.

4.14 Transforming care partnerships will need to engage with and involve a broad range of people, including: all the CCGs; NHS England specialised commissioners; local authorities, including those commissioners responsible for adult and children's social care, education, housing and safeguarding; people with a learning disability and/or autism, their families/carers; clinicians; third-sector organisations; the police and those responsible for the criminal justice system; and relevant Local Education and Training Boards.

4.15 We will support local commissioners in this phase to mobilise the necessary project management resource, governance arrangements and partnership working across the range of organisations who need to be involved.

Understanding the starting point

4.16 Transforming care partnerships will need to base their plans on a strong understanding of: the population they are seeking to achieve better outcomes for (both current inpatients and those in the community at risk of admission without the right support); how much money CCGs, local authorities and NHS England specialised commissioners are currently spending on health and care for that population; which providers are delivering what services for that spend; and how the system is currently performing, its strengths and weaknesses.

4.17 In addition to the above areas will need to understand the estate and housing requirements to implement their plans, and establish whether there are

available capital receipts which could be recycled as part of this programme – including those relating to the estimated 2,000 properties used by councils or social landlords to provide housing or care to people with a learning disability but under an NHS charge.

4.18 NHS England, LGA and ADASS will provide data and access to subject matter experts to support local commissioners to understand the strengths and weaknesses of existing local services.

Developing a vision for the future and designing a future model of care

4.19 We will support local commissioners to develop a shared vision of how services will change, in line with the national service model.

4.20 NHS England, LGA and ADASS will support local areas with independent facilitation to bring local stakeholders together to design a jointly-owned future model of care. We will also support commissioners to access a range of experts, such as people with a learning disability and/or autism and their family carers who are 'experts by experience', clinicians, people with experience of person-centred planning - and integrated personal budgets - and providers of innovative community care and support.

Implementation planning

4.21 Local commissioners will need to draw up a road map for implementation, covering issues such as finance, workforce development, market development, or changes to estates.

4.22 NHS England, LGA and ADASS will provide technical expertise to support local areas with implementation planning. Building on the review process developed for assuring fast track plans and in alignment with the process for assuring CCGs' annual plans, local implementation plans will be reviewed and challenged by a range of stakeholders including people with a learning disability and/or autism, their families/carers, clinicians and commissioners from other areas.

Delivery

4.23 We expect local transforming care partnerships to have drawn up robust implementation plans and be delivering against them from 1 April 2016.

4.24 A cross-sector alliance of organisations will support these transforming care partnerships to deliver on this ambitious agenda.

4.25 Working alongside local commissioners, NHS England, LGA and ADASS will work with providers and their representative bodies to rapidly mobilise new housing and care services in the community. This work will focus on supporting providers to:

- Support commissioners to redesign services, including through advice on commissioning plans and market development, expertise on legal frameworks (such as the Mental Capacity Act and Deprivation of Liberty

Safeguards [DoLS]), and supporting individuals and families to design person-centred packages of support
- Deliver appropriate community-based services at scale, including through joint work between social care providers and providers of clinical services, and developing local responses to emergencies
- Train the local workforce within and beyond their organisations (e.g. through PBS training)
- Access the investment needed to expand and improve their offer at pace, including potentially through social investors
- Secure the capital required to deliver high-quality housing in community settings, including through potential social investment solutions such as charity bond issues (see case study below)

Case study – Retail Charity Bonds

In 2014, the first charity bond to be listed on the London Stock Exchange's Order Book for Retail Bonds was launched.

The bond, which raised £11 million to fund accommodation for people with a learning disability, was so oversubscribed it closed its offer period two and half weeks early.

The bond was launched by Retail Charity Bond plc and the funds have been used by Golden Lane Housing, the national charity which provides housing for people with a learning disability, to invest in buying and adapting much-needed community based housing across the country for over 100 people with a learning disability.

4.26 Alongside this work with providers to mobilise new services and housing in the community, we will explore the establishment of a national collaborative improvement programme (co-ordinating peer-learning and shared problem-solving between local areas), and a national accelerated support team able to work intensively with local areas with the biggest challenges and/or struggling to make progress.

4.27 HEE, Skills for Health and Skills for Care will collaborate to support the development of an appropriately skilled workforce to build the capacity to support people in the community. As far as possible, this will include working to support current inpatient staff to develop skills to work in the community. Every transforming care partnership will have a lead HEE contact to support them with planning and delivering workforce change. That lead contact will help them access relevant tools (such as competency frameworks), funding streams and training (for example leadership development or training to support staff in mainstream services to understand the needs of people with a learning disability and/or autism). Annex B sets out some of these resources in more detail.

4.28 NHS England, Monitor and the TDA will work together to support hospitals proactively to shift their business models, increasingly offering NHS assessment and treatment services in the community.

4.29 We will work with the CQC, Monitor, the TDA and local commissioners to ensure that inpatient units are only closed when people living in those units are supported to move in an appropriate and timely way to high quality services that can meet their needs. The CQC is also undertaking work to review their fundamental standards against the service model. When regulating active services (or those seeking registration) these fundamental standards will be used and robust action taken if services are not compatible with these and therefore the new service model.

4.30 We will review governance arrangements for the Transforming Care programme at a national level to ensure it reflects this alliance of organisations supporting local areas to deliver.

Monitoring progress

4.31 Nationally, we will monitor progress on delivery against the overarching outcomes we expect transformation to achieve, namely:

- Reduced reliance on inpatient services (closing hospital services and strengthening support in the community)
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings

4.32 Reduced reliance on inpatient services will be monitored using Assuring Transformation data,[21] and from January 2016 the Mental Health Services Single Data Set[22] (MHSDS), incorporating data from the Learning Disabilities Census and Assuring Transformation dataset.

4.33 We will explore with transforming care partnerships an appropriate way to monitor improvements in quality of life, but are minded to support areas to roll-out use of the Health Equality Framework tool[23] to monitor quality of life. In particular, we are considering how to support the use of this tool to understand changes to quality of life as people are supported to move out of inpatient services.

4.34 We will support the development of a basket of indicators to monitor improvements in quality of care, aligned with the newly developed service model. This basket of indicators will, as far as possible, be based on existing data sources currently collected in the NHS and social care.

4.35 Furthermore, as part of the role out of the CTRs across the NHS, NHS England will work with system partners on introducing a metric for measuring the outcomes of this process. This may involve introducing a Patient Reported Outcome Measure (PROM) and/or a Patient Reported Experience Measure

[21] http://www.hscic.gov.uk/article/6328/Reports-from-Assuring-Transformation-Collection
[22] This is replacing the Mental Health and Learning Disabilities dataset
[23] http://www.ndti.org.uk/publications/other-publications/the-health-equality-framework-and-commissioning-guide1/

(PREM). Development of this CTR outcome measure will have to involve people with a learning disability and/or autism, as well as their families/carers, clinicians, providers and commissioners to ensure it is robust and can be used at a national level to assess progress.

4.36 We will also revise the Learning Disability Self-Assessment Framework (SAF) and the Autism Self-Assessment Framework so that they reflect how well local areas are doing in building up support in the community and closing inpatient services.

4.37 With all the measures outlined above, it is important that people are supported to understand who will see their information, how their information will be used and make decisions about sharing their information. People should be given help to do this. For those people who lack capacity, they should still be involved as much as possible in any decisions made in their best interests.

4.38 NHS England will also support people with a learning disability to check the quality of services themselves, through a programme of work to establish a centralised system for NHS Quality Checking by people with a learning disability. Quality checker services train and support experts by experience to audit service quality. Quality checkers use their own experiences to make assessment on the quality of care and support, and to give a view that can be often missing from other forms of quality review. This entails using indicators of quality which people with a learning disability themselves consider to be relevant and important and which may therefore differ from those which have historically been used. Quality checkers with a learning disability will themselves carry out the evaluation, part of which will involve talking to service users about their experiences and views of the service in question. Evaluation of quality checking programmes show them to be an effective and efficient use of resources and to be associated with increases in quality and improved outcomes.

4.39 In addition, pilot work supported by NHS England has also demonstrated the potential of ‘Always Events’ to strengthen the voices of people with a learning disability and/or autism in the quality assurance of services.

4.40 Lancashire Care NHS Foundation Trust - in partnership with the Institute for Healthcare Improvement (IHI), the Picker Institute Europe and NHS England - has co-produced with people with a learning disability a set of ‘Always Events’ to improve the quality and consistency of transitions within and between services. NHS England will expand its work on ‘Always Events’, share the case study from Lancashire and produce a toolkit with IHI to support the further use of this tool in order to improve the responsiveness and accountability of services.

Financial underpinnings

4.41 A new financial framework will underpin and enable transformation.

4.42 Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model of care will therefore be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. We estimate that the closure of inpatient services of the scale set out in chapter 3 will release hundreds of millions of pounds for investment in better support in the community.

4.43 To enable that to happen, NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare. CCGs, NHS England specialised commissioning and local authorities will be supported to, where appropriate, put in place governance and financial mechanisms to align or pool resources and manage financial risk. The degree of change and financial risk will inevitably vary across localities, and we will support local commissioners to base decisions on transparent, open-book discussions, focussed on achieving the best outcomes for the people they serve.

4.44 For people who have been an inpatient for five years or more (approximately one third of the total inpatient population) and who are ready for discharge, we expect the transformational change required to be one of 'resettlement' out of hospital and into a more suitable home, as opposed to redesigning services to reduce the 'revolving door' of admissions and discharges. For this group, money will 'follow the individual' through dowries.

4.45 Dowries will be paid by the NHS to local authorities for people leaving hospital after continuous spells in inpatient care of five years or more at the point of discharge. We expect that NHS England will pay for dowries when the inpatient is being discharged from NHS England-commissioned care, and that CCGs will pay for dowries when the individual is being discharged from CCG-commissioned care. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual. An annual confirmation of dowry-qualifying individuals should be undertaken by local authorities and CCGs. Dowries are to be prospective only, and so should not be applied to any patients that have already been discharged. They should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date). They should apply pro rata in the start and finish year. To ensure that the costs of the future model of care fit within the existing funding envelope, it is important

that dowries are set at a level which is consistent with this principle. The absolute level of the dowry is not expected to be set nationally, but is to be left to local discussions which should be subject to the principles set out here. In addition to paying for these dowries, the NHS will continue to fund continuing healthcare (CHC) and relevant Section 117 aftercare.

4.46 In addition, from November 2015 *Who Pays* guidance - determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

4.47 Transformation of this scale will entail significant transition costs, including the temporary double running of services as inpatient facilities continue to be funded whilst new community services are established. The extent of the transition costs will depend on the efficiency of the bed closure programme, and the timing and extent of required new community investment. We will work with commissioners and providers to support the closure of inpatient capacity and development of new community services as efficiently as possible, but we recognise that non-recurrent investment will still be necessary. To support local areas with these transitional costs and building on the approach tested with fast track areas, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

4.48 In addition to this, £15 million capital funding over three years will be made available, and NHS England will explore making further capital funding available following the Spending Review.

4.49 As set out in the national service model, alongside these new financial underpinnings to enable transformation we expect to see a significant growth in personalised funding approaches (personal budgets, personal health budgets, and integrated personal budgets as well as education, health and care plans). Local transformation should, for instance, be aligned with existing requirements for CCGs to set out a ‘local offer’ on personal health budgets.

4.50 In some parts of the country, local transformation plans will also need to align with Integrated Personal Commissioning (IPC) pilots. IPC sites are currently testing approaches to enable people to purchase their care (including clinical services currently commissioned using NHS standard contracts) through personal budgets, combining resources from health, social care and other funding sources where applicable. The work these sites are undertaking includes linking cost and activity data across services and trialling new contracting and payment approaches that enable the money to be used differently. As IPC sites progress their work, we will support local transforming care partnerships to learn from them and apply the lessons to their own local areas.

Conclusion

This document started with a simple vision that people with learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying valued lives and to be treated with dignity and respect. They should have a home, be able to develop and maintain relationships, and get the support they need to live healthy, safe and fulfilling lives in the community.

For all the frustration of recent years, it is a vision that we can make real. Thousands of people with a learning disability and/or autism are today supported in the community who would years ago have lived in hospitals. There is good practice across the country. There are thousands of people with the expertise and commitment to make this shift happen, from people with a learning disability and/or autism themselves, families/carers as well as frontline clinicians and staff. We have local leaders across social care, the NHS and criminal justice system ready and willing to take up the challenge. At a national level there is an alliance of organisations committed to breaking down the barriers to change, supporting local leaders to make a difference.

Together we have an opportunity to transform thousands of lives. Together we must seize the day and deliver.

Annex A – Proposed CCG clusters for transforming care partnerships

This table shows how CCGs currently propose to cluster together to work with local authorities and NHS England specialised commissioning to build up community services and close inpatient provision that is no longer needed.

Transforming Care Partnership	Clinical Commissioning Group (CCG)
South Worcestershire, Redditch, Bromsgrove & Wyre Forest	NHS South Worcestershire CCG
	NHS Wyre Forest CCG
	NHS Redditch and Bromsgrove CCG
Hereford	NHS Herefordshire CCG
Coventry, Rugby, South Warwickshire & Warwickshire North	NHS Coventry and Rugby CCG
	NHS South Warwickshire CCG
	NHS Warwickshire North CCG
Birmingham CrossCity, Birmingham South Central & Solihull	NHS Birmingham CrossCity CCG
	NHS Birmingham South and Central CCG
	NHS Solihull CCG
Walsall	NHS Walsall CCG
Black Country	NHS Dudley CCG
	NHS Sandwell and West Birmingham CCG
	NHS Wolverhampton CCG
Derbyshire	NHS Erewash CCG
	NHS Southern Derbyshire CCG
	NHS Hardwick CCG
	NHS North Derbyshire CCG
Nottinghamshire	NHS Mansfield and Ashfield CCG
	NHS Bassetlaw CCG
	NHS Newark and Sherwood CCG
	NHS Nottingham City CCG
	NHS Nottingham North and East CCG
	NHS Nottingham West CCG
	NHS Rushcliffe CCG
Suffolk	NHS Ipswich and East Suffolk CCG
	NHS West Suffolk CCG
Norfolk	NHS North Norfolk CCG
	NHS Norwich CCG

	NHS South Norfolk CCG
	NHS West Norfolk CCG
	NHS Great Yarmouth and Waveney CCG
Cambridge and Peterborough	NHS Cambridgeshire and Peterborough CCG
Essex	NHS Basildon and Brentwood CCG
	NHS Castle Point and Rochford CCG
	NHS Mid Essex CCG
	NHS North East Essex CCG
	NHS Southend CCG
	NHS Thurrock CCG
	NHS West Essex CCG
Bedford, Luton and Milton Keynes	NHS Bedfordshire CCG
	NHS Luton CCG
	NHS Milton Keynes CCG
Hertfordshire	NHS East and North Hertfordshire CCG
	NHS Herts Valleys CCG
Nene and Corby	NHS Nene CCG
	NHS Corby CCG
Lincolnshire	NHS Lincolnshire East CCG
	NHS Lincolnshire West CCG
	NHS South Lincolnshire CCG
	NHS South West Lincolnshire CCG
Leicestershire	NHS East Leicestershire and Rutland CCG
	NHS Leicester City CCG
	NHS West Leicestershire CCG
Shropshire	NHS Shropshire CCG
	NHS Telford and Wrekin CCG
Staffordshire	NHS East Staffordshire CCG
	NHS North Staffordshire CCG
	NHS South East Staffordshire and Seisdon Peninsular CCG
	NHS Stafford and Surrounds CCG
	NHS Cannock Chase CCG
	NHS Stoke-on-Trent CCG
Gloucestershire	NHS Gloucestershire CCG
Wiltshire and Swindon	NHS Swindon CCG
	NHS Wiltshire CCG
Bristol, Bane and South	NHS Bristol CCG

Gloucestershire	NHS South Gloucestershire CCG
	NHS Bath and North East Somerset CCG
Somerset and North Somerset	NHS North Somerset CCG
	NHS Somerset CCG
Cornwall	NHS Kernow CCG
Devon	NHS North, East, West Devon CCG
	NHS South Devon and Torbay CCG
Kent and Medway	NHS Ashford CCG
	NHS Canterbury and Coastal CCG
	NHS Dartford, Gravesham and Swanley CCG
	NHS Medway CCG
	NHS South Kent Coast CCG
	NHS Swale CCG
	NHS Thanet CCG
	NHS West Kent CCG
Sussex	NHS Brighton and Hove CCG
	NHS High Weald Lewes Havens CCG
	NHS Eastbourne, Hailsham and Seaford CCG
	NHS Hastings and Rother CCG
	NHS Coastal West Sussex CCG
	NHS Crawley CCG
	NHS Horsham and Mid Sussex CCG
Surrey	NHS Guildford and Waverley CCG
	NHS North West Surrey CCG
	NHS Surrey Downs CCG
	NHS East Surrey CCG
	NHS Surrey Heath CCG
Buckinghamshire	NHS Aylesbury Vale CCG
	NHS Chiltern CCG
Berkshire	NHS Bracknell and Ascot CCG
	NHS Slough CCG
	NHS Windsor Ascot and Maidenhead CCG
	NHS Newbury and District CCG
	NHS North and West Reading CCG
	NHS South Reading CCG
	NHS Wokingham CCG
Hampshire & Isle of Wight	NHS North East Hampshire and Farnham CCG
	NHS North Hampshire CCG

	NHS Portsmouth CCG
	NHS South Eastern Hampshire CCG
	NHS Southampton CCG
	NHS West Hampshire CCG
	NHS Fareham and Gosport CCG
	NHS Isle of Wight CCG
Dorset	NHS Dorset CCG
Wirral, Cheshire & Chester	NHS Wirral CCG
	NHS West Cheshire CCG
	NHS Eastern Cheshire CCG
	NHS South Cheshire CCG
	NHS Vale Royal CCG
Halton, St Helens, Warrington, Knowsley	NHS Halton CCG
	NHS St Helens CCG
	NHS Warrington CCG
	NHS Knowsley CCG
Liverpool, Sefton, Southport & Formby	NHS South Sefton CCG
	NHS Southport and Formby CCG
	NHS Liverpool CCG
Greater Manchester	NHS Bolton CCG
	NHS Bury CCG
	NHS Central Manchester CCG
	NHS Heywood, Middleton and Rochdale CCG
	NHS North Manchester CCG
	NHS Oldham CCG
	NHS Salford CCG
	NHS South Manchester CCG
	NHS Stockport CCG
	NHS Tameside and Glossop CCG
	NHS Trafford CCG
	NHS Wigan Borough CCG
Lancashire	NHS Blackburn with Darwen CCG
	NHS Blackpool CCG
	NHS Chorley and South Ribble CCG
	NHS East Lancashire CCG
	NHS Fylde and Wyre CCG
	NHS Greater Preston CCG
	NHS Lancashire North CCG

	NHS West Lancashire CCG
Cumbria and NE	NHS Cumbria CCG
	NHS Newcastle Gateshead CCG
	NHS North Tyneside CCG
	NHS Northumberland CCG
	NHS South Tyneside CCG
	NHS Sunderland CCG
	NHS Darlington CCG
	NHS Durham Dales, Easington and Sedgefield CCG
	NHS Hartlepool and Stockton-on-Tees CCG
	NHS North Durham CCG
	NHS South Tees CCG
North Yorkshire	NHS Hambleton, Richmondshire and Whitby CCG
	NHS Harrogate and Rural District CCG
	NHS Scarborough and Ryedale CCG
	NHS Vale of York CCG
Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale	NHS Barnsley CCG
	NHS Wakefield CCG
	NHS North Kirklees CCG
	NHS Greater Huddersfield CCG
	NHS Calderdale CCG
Bradford	NHS Bradford Districts CCG
	NHS Bradford City CCG
	NHS Airedale, Wharfdale and Craven CCG
Leeds	NHS Leeds North CCG
	NHS Leeds South and East CCG
	NHS Leeds West CCG
Sheffield, Doncaster, Rotherham, North Lincolnshire	NHS Doncaster CCG
	NHS Rotherham CCG
	NHS North East Lincolnshire CCG
	NHS North Lincolnshire CCG
	NHS Sheffield CCG
East Riding & Hull	NHS East Riding of Yorkshire CCG
	NHS Hull CCG
London North West	NHS Brent CCG
	NHS Central London CCG

	NHS Ealing CCG
	NHS Hammersmith and Fulham CCG
	NHS Harrow CCG
	NHS Hillingdon CCG
	NHS Hounslow CCG
	NHS West London CCG
London North, Central & East	NHS Barking and Dagenham CCG
	NHS Barnet CCG
	NHS Camden CCG
	NHS City and Hackney CCG
	NHS Enfield CCG
	NHS Haringey CCG
	NHS Havering CCG
	NHS Islington CCG
	NHS Newham CCG
	NHS Redbridge CCG
	NHS Tower Hamlets CCG
	NHS Waltham Forest CCG
London South East	NHS Bexley CCG
	NHS Bromley CCG
	NHS Greenwich CCG
	NHS Lambeth CCG
	NHS Lewisham CCG
	NHS Southwark CCG
London South West	NHS Croydon CCG
	NHS Kingston CCG
	NHS Merton CCG
	NHS Richmond CCG
	NHS Sutton CCG
	NHS Wandsworth CCG
Oxfordshire	NHS Oxfordshire CCG

Annex B – Workforce development

i. In every part of the country there are people with the skills and experience to deliver effective care to people with a learning disability and/or autism. These people can be found within health and social care and amongst the people with a learning disability and/or autism themselves, as well as families/carers that support individuals in their own home.

ii. As such, an essential part of delivering each joint transformation plan relies on how areas can harness these skills.

iii. Areas need to develop, focus and refine the skills needed to enable them to work in a different way. They need to manage risk efficiently and have robust and effective ways of intervening in crisis situations that lead to the best possible solutions in the least restrictive environment.

iv. Each area needs to establish mechanisms to understand the skills and competencies that are required to support the specific needs of every individual. Only then will they be able to commission a service that is flexible enough to care for each person and their own specific circumstances. The development of new and innovative approaches to supporting people will be reliant upon the development of a flexible and skilled workforce equipped to adapt and adopt new practices. This may involve commissioning new roles from those traditionally employed within the current provision.[24] Those commissioned to provide such services will need to define competencies and skills required, assess the capability currently available within their workforce, and access appropriate training and development. This will include developing skills to deliver services across all ages in the areas of mental health, autism, managing behavioural problems and offending behaviour.

v. HEE alongside partner organisations Skills for Care and Skills for Health will offer practical support with the aim to:

- **Equip commissioners with the tools and confidence to commission for workforce skills and competencies.** Commissioners are an essential part of the workforce that needs development and support to deliver the new service model. This includes enhancing existing service provision, creating new service models and commissioning beyond the traditional service boundaries, for example placing learning disability nurses in primary and secondary care in order to support health and care professionals to make better decisions. Skills for Care have developed a workforce commissioning model that provides a systematic way of linking service commissioning with workforce commissioning and financial strategy. This can be found here

vi. There are several models for testing workforce assumptions and undertaking Strategic Workforce planning, including Integrated Workforce Planning

[24] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309153/Strengthening_the_commitment_one_year_on_published.pdf

Solutions from Skills for Health, and Skills for Care's Workforce Capacity Planning guidance.

- **Work with existing service providers to review the skills and competencies within their existing workforce to identify education and training needs, and facilitate transition to a new way of working.** HEE in partnership with Skills for Health have developed a skills and competency framework which can be utilised to undertake a training needs analysis of the existing workforce, and to build a competency based team model against which new and existing roles can be mapped. The framework, alongside an illustrative animated video, can be found here: HEE Skills & Competency Framework

vii. We are in the process of developing an interactive tool to support the implementation and use of the competence framework.

viii. The Positive Behavioural Support (PBS) Coalition have published a PBS Competency Framework. For ease of use, the PBS competencies have been mapped into the HEE Skills and Competency Framework.

ix. Whilst this framework has been developed primarily for the health care workforce it can be utilised in a range of services. Skills for care have developed a strategy for the social care sector to support functional and employability skills (Core Skills), which impact directly on the quality of care and support services.

- **Ensure that education and training to enable the wider workforce is able to meet the needs of people with a learning disability in all care settings**. Recognising that most people with a learning disability have their health and care needs met by mainstream health care services, HEE commissioned the development of education and training resources 'Learning Disability Made Clear' that can be used by staff in a range of health and care settings to increase their knowledge and support how services can make adjustments to meet specific needs

x. A suite of existing resources developed to raise awareness of the needs of people with autism, have been reviewed and located in one place to enable individuals and organisations to select the most appropriate resource for their needs. A marketing and promotion strategy is underway to ensure these resources are widely accessed by employers, employees, volunteers and carers across the country. These can be found here.

xi. In addition to the above, work is being undertaken to develop specific learning disability and autism skills in the mainstream mental health workforce on whom we will become increasingly reliant as specialist services become more integrated.

- **Developing leadership capability across the system including commissioners, service providers and carers to promote innovation and change services to focus on people's needs.** HEE, Skills for Health and Skills for Care will coordinate access to the various provision and funding streams available across agencies to ensure that creative and innovative leadership activities are supported as part of the national transformation plan

Annex C – Notes on data used in this document

All modelling to produce planning assumptions and charts was based on calculating inpatient rates per million population. The following notes apply to all charts used in this document which describe projected reductions in fast track bed usage and current geographical variation in reliance on inpatient care across England.

- All inpatient rates are based on GP registered population aged 18 and over as at 2013/14
- Inpatient numbers include children under the age of 18 but these patients represent less than 5% of the total inpatient population
- High secure services have been excluded (65 patients[25])

Data on the current position and projections for fast track areas is taken from the fast track plans, but projections exclude Worcestershire (part of Arden, Herefordshire and Worcestershire Fast Track).

The data set used to calculate the current geographical variation as at 31 July 2015 combines information on CCG-commissioned patients from the Assuring Transformation collection and data on NHS England-commissioned patients from NHS England's Local Trackers (this includes information on the home CCG of NHS England-commissioned patients). This means that the presentation of inpatient data is based on where patients originally come from, not where their hospital is located.

Assuring Transformation data is collected and published by The Health and Social Care Information Centre (HSCIC). Assuring Transformation data is presented in accordance with HSCIC rules on suppressed data for collections involving small numbers of records.

Not all NHS England-commissioned patients in the Local Tracker data could be matched to a CCG of origin, and these patients are therefore omitted from the analysis of geographical variance on a Transforming Care Partnership level. The geographical analysis presented in Figures 2 and 3 assigns these patients to the locality of their commissioner.

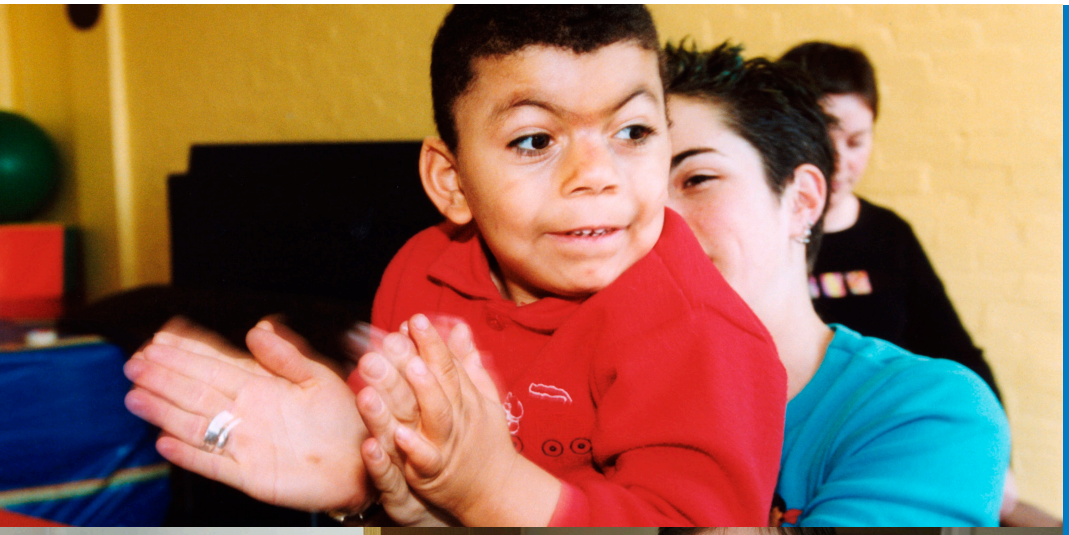
[25] Number of inpatients in high secure settings suppressed in accordance with HSCIC rules on suppressed data for collections involving small numbers of records. Figure correct as at 31st July 2015.

Local Government Association

directors of adass adult social services

NHS England

Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition



Service model for commissioners of health and social care services

October 2015

Contents

Introduction	**4**
About this document	**5**
Who this service model is about	**8**
Good services for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition	**10**
Annex A – terminology	**30**
Annex B – common needs and common shifts in service response	**33**
Annex C – understanding the local population	**38**
Annex D – reference group membership	**39**

Introduction

Service model vision statement

Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition* have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life.

"The success in this lies not within systems and processes but within human connections, commitments, accountability and sustainable relationships that are non-adversarial."

Commissioner

The principles which underpin this service model build on what have been described before, including in Valuing People and Valuing People Now, all of which focus on rights, independence, choice and inclusion for people with a learning disability and/or autism.

Good practice guidance around the commissioning of services for people with a learning disability and/or autism who display behaviour that challenges, including the 1993 and 2007 Mansell reports, describe the need to develop high quality local services that understand and support people, and reduce the reliance on out-of-area placements. They focus on ensuring the best outcomes for people by working in partnership with individuals and families/carers and through adopting person-centred approaches – vital to delivering independence and control for people and ensuring that the person's wishes and aspirations for their own life are at the centre of their care and support arrangements.

There has been a renewed commitment to transforming the way in which care and support is delivered to people with a learning disability and/or autism who display behaviour that challenges. In line with the provisions of the Children and Families Act and the Care Act, which focus on outcomes, personalisation and wellbeing, this commitment focuses on strengthening support in the community by building on the provision of preventative support that will avoid crises and help support people to be active members of their communities, with all the benefits that brings.

This service model brings together the current good practice taking place in local areas, and that which has previously been described for this group of people. It recognises that improvements are typically underpinned by visionary leadership, a focus on human rights based approaches, workforce development, co-production and a preparedness to reflect and learn. It aims to support commissioners across health and social care to work together to commission the range of services and support required to meet the needs of this diverse group.

* Hereafter people with a learning disability and/or autism

About this document

Since the investigation into the abuse at Winterbourne View and other similar hospitals[1], there has been a cross-government commitment to transform care and support for people with a learning disability and/or autism who display behaviour that challenges, including behaviour that can lead to contact with the criminal justice system. This is focused on building up community capacity and reducing inappropriate hospital admissions.

Services will not look the same all over the country. Each local area is different: local populations have different needs, and their range of providers have different strengths and weaknesses. Each local area will therefore need to draw up its own model for how services should look in future, based on an agreed service model.

However, there will be some national consistency in what services should look like across local areas, based on established best practice. This document seeks to describe that national consistency, while giving commissioners the flexibility to design services that best fit the needs of their local population. It sets out to provide clarity on 'what good looks like' for health, social care and housing services for people with a learning disability and/or autism.

Who this service model is for

This service model is for all health and social care commissioners – not just learning disability commissioners; in particular, this includes mental health commissioners, Continuing Health Care (CHC) commissioners, public health and children's commissioners. It covers the full range of commissioning – strategic, operational and individual/micro commissioning.

Different types of commissioning

[1] 'Hospital' in this context refers to those hospital facilities (registered by the CQC) which are providing mental or behavioural healthcare in England for people with a learning disability and/or autism, or the equivalent organisations in Wales and Scotland for English commissioned patients.

Commissioners should ensure that plans impacting on people of all ages with a learning disability and/or autism align with related initiatives, and identify opportunities for joint working. This should include commissioners seeking to align these plans with the development of their Local Transformation Plans for Children and Young People's Health and Wellbeing, local action plans under the Mental Health Crisis Concordat and the 'local offer' for personal health budgets.

Scope of the service model

This service model focuses on services and packages of care and support funded by the NHS and local government, as well as NHS/local government interfaces with other services (e.g. education), but not those services funded by other public sector agencies themselves (e.g. schools).

This does not mean, however, that other public services and organisations do not also need to review and improve the way they support and provide services for children, young people and adults with a learning disability and/or autism. It is essential that links across all local system partners are established both to ensure a joined-up and effective approach to supporting people, with clearly identified care and support pathways, and to maximise opportunities for sharing knowledge, skills and support across agencies and systems. This is in line with existing NICE guidelines (see below) on challenging behaviour and learning disabilities which recommends the need for leadership teams across health, social care and education to develop care pathways for people including transitions between and within services.

How the service model was developed

A reference group[2] was set up to provide expert advice on the development of the model, bringing together a range of stakeholders. In addition, six 'fast-track' areas[3] used a draft version of the service model as they developed plans to transform services for people with a learning disability and/or autism over the summer of 2015 and provided feedback. Through a process of engagement, NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), sought the views of clinicians, commissioners, providers, families and people with a learning disability and/or autism.

This service model is intended for a particular juncture in the transformation of services for people with a learning disability and/or autism. It builds on existing NICE guidance (such as that on challenging behaviour and learning disabilities and that on autism and will be superseded as good practice develops and in particular once NICE service model guidance is published in 2017.

We do not expect the services and support described here to be put in place over night, but we do expect all areas to implement this service model over the next three years.

[2] See Annex D for reference group membership.
[3] The 'fast-track' areas are Greater Manchester; Lancashire; Cumbria and the North East; Arden, Herefordshire and Worcestershire; Nottinghamshire; and Hertfordshire.

The transforming care programme

The service model forms part of a national plan to support commissioners across the country to formulate joint transformation plans. This in turn is part of a much broader programme of work led by the Department of Health, NHS England, the LGA, ADASS, the Care Quality Commission (CQC), and Health Education England (HEE) to transform services.

The national plan describes in further detail the mechanisms for achieving transformation, including the financial underpinnings and commissioning arrangements, which are key to delivering on the vision outlined in this service model. Other aspects of the wider transforming care programme will also support its delivery, including the development of effective assurance metrics; robust inspection/ regulation; and development of the workforce.

Who this service model is about

Who this is about[4]

This service model is about those people with a learning disability and/or autism who display behaviour that challenges, including behaviour which is attributable to a mental health condition[5].

This includes people of all ages and those with autism[6] (including Asperger's syndrome) who do not also have a learning disability (as well as those who have both a learning disability and autism), and includes those people with a learning disability and/or autism whose behaviour can lead to contact with the criminal justice system.[7]

Services to meet diverse and complex needs

This is an extremely diverse group of people and the support they require will be highly individualised - tailored to their particular needs, strengths, interests and in some cases the risks they pose to others (all of which might change over time).

However, there are some common needs that services in any one local area need to ensure they have the capacity to address. There are also some common deficiencies in how services currently address those needs in the community, with the result that, too often, people may end up in hospital (including through diversion from the criminal justice system) at great human cost to themselves and their families/carers[8], and when those circumstances could have been avoided. There are therefore, also some common shifts that services will often need to make.

[4] For simplicity, henceforth when we refer to 'everyone' or 'people' in this document, we are referring to this defined group of people (children, young people and adults) unless otherwise stated and when we refer to 'people with learning disabilities and/or autism, we are referring to 'people with learning disabilities and/ or autism who display behaviour that challenges, including those with a mental health condition.

[5] See Annex A for definitions: behaviour that challenges, learning disability and autism.

[6] Throughout this document we use the term 'autism' as an umbrella term for all Autistic Spectrum Conditions, including Asperger Syndrome.

[7] A small percentage of people with a learning disability and/or autism engage in behaviour that may lead to contact with the criminal justice system, and potentially diversion to a hospital setting. They are included as a distinct group within this service model because their specific needs have not always been recognised; the model presents an opportunity to develop the support and services they may require.

[8] In this document we use the term 'carer' to mean those people who provide unpaid support to someone. This is often a family member, but not always. We refer to people who provide paid support as 'paid support and care staff'.

The following groupings help to illustrate some common needs amongst the diversity of the population that this service model is about:

- Children, young people or adults with a learning disability and/or autism who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
- Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
- Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).
- Children, young people or adults with a learning disability and/or autism, often with lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

This is not an exhaustive list. These groupings cannot cover the complexities of every individual, nor all the causes of certain behaviours. Individuals do not 'slot neatly' into any single grouping – they overlap, people's needs change over time, and often a large part of the challenge for local services will be to understand what combination of factors lies behind an individual's behaviour.

These groupings are a means of demonstrating the range and complexity of the group described within the service model and some common themes and needs that will require consideration by commissioners. Annex B provides further detail on these common needs and the common shifts in service responses that are required.

Good services for people with a learning disability and/or autism

This section describes what good services and support look like for people with a learning disability and/or autism who display behaviour that challenges, including behaviours which may result in contact with the criminal justice system.

It is structured around **nine core principles** that are stated from the perspective of the reasonable expectations of someone who might use such services. Additional supplementary information for commissioners has been published alongside this to provide further detail on each aspect of the model outlined.

The human rights of people who use services are incontrovertible and must be upheld at all times; consequently there are a number of **'golden threads'** that run consistently through the nine principles described and which should therefore be reflected in local commissioning strategies:

- **Quality of life** – people should be treated with dignity and respect. Care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations; it should be about maximising the person's quality of life regardless of the nature of their behaviours that challenge. There should be a focus on supporting people to live in their own homes within the community, supported by local services.
- **Keeping people safe** – people should be supported to take positive risks whilst ensuring that they are protected from potential harm, remembering that abuse and neglect can take place in a range of different environments and settings. There should be a culture of transparent and open reporting, ensuring lessons are learned and acted upon.
- **Choice and control** – people should have choice and control over their own health and care services; it is they who should make decisions about every aspect of their life. There is a need to 'shift the balance of power' away from more paternalistic services which are 'doing to' rather than 'working with' people, to a recognition that individuals, their families and carers are experts in their own lives and are able to make informed decisions about the support they receive. Any decisions about care and support should be in line with the Mental Capacity Act. People should be supported to make their own decisions and, for those who lack capacity, any decision must be made in their best interests involving them as much as possible and those who know them well.
- **Support and interventions** should always be provided in the least restrictive manner. Where an individual needs to be restrained in any way – either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible, in line with Positive and Proactive Care.

- **Equitable outcomes**, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework. The starting point should be for mainstream services, which are expected to be available to all individuals, to support people with a learning disability and/or autism, making reasonable adjustments where necessary, in line with Equality Act legislation, with access to specialist multi-disciplinary community based health and social care expertise as appropriate.

The vision described in this service model

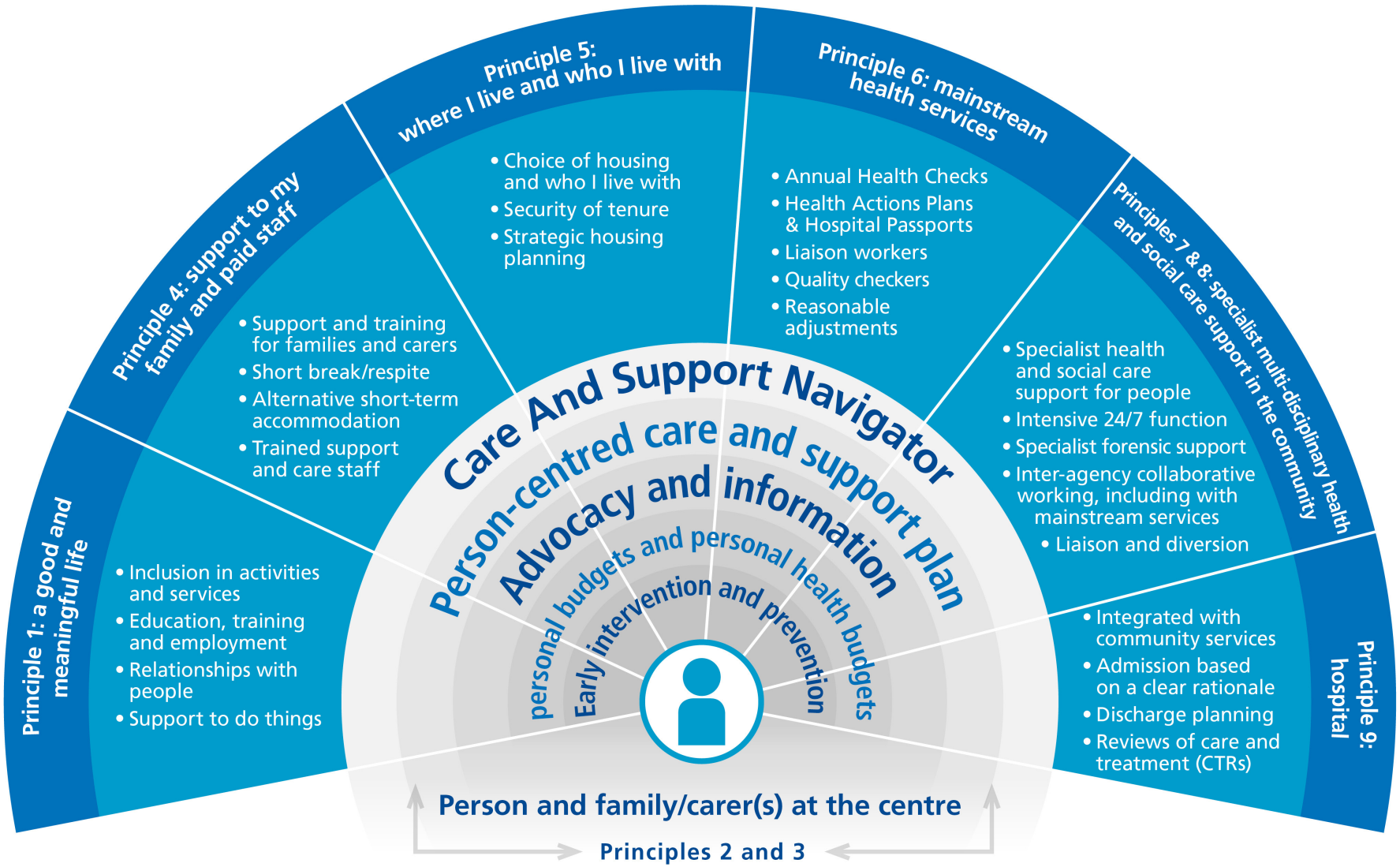
A whole-system response is the key to delivering high quality services and support for people. For this to be a reality, services need to demonstrate a strong commitment to a shared value base which places individuals and their quality of life at the heart of all they do. This value base should reflect the 'golden threads' and be evident on the basis of the capable environments[9] within which care and support is delivered. Capable environments are characterised by: positive social interactions, support for meaningful activity, opportunities for choice, encouragement of greater independence, support to establish and maintain relationships and mindful and skilled family/carers and paid support and care staff.

The service model describes a range of services and supports that should be in place within any local area. Depending on their needs and circumstances, people with a learning disability and/or autism and their families/carers should be able to draw upon the support described in the model in a way that is right for them. They should also be supported to navigate their way through an often complex and anxiety provoking system.

Just as people's situations and experiences vary (for example, some may have a long history of behaviour that challenges, whilst others may develop such behaviours as a result of transient physical or mental health problems), they will become known to different local services in different ways and at different points in their lives. What works and is needed for each individual will look different, and not all aspects of the service model will apply, or be required by everyone.

However, the starting point for everyone should be about **access to support that is based on individual need**, through establishing an understanding of the factors, both historic and current, that have contributed to the individual's behaviour. Care and support should then be delivered with the aim of improving the person's quality of life. In order for this to be successful, it will require **multi-disciplinary** and **multi-agency** working, as well as skilled informed responses from specialist health and social care services, in partnership with the person and those who provide day-to-day support.

[9] See: http://www.kcl.ac.uk/sspp/policy-institute/scwru/news/2014/newsfolder/McGill-et-al-Capable-environments.pdf



Service Model

Commissioners understand their local population now and in the future

1. I have a good and meaningful everyday life.

> "When I move to my flat, the most important thing is friends."
> "It's all about relationships – with my friends, my family and my staff."
> **Individuals with a learning disability in a secure hospital**

1.1 Children, young people and adults with a learning disability and/or autism who display[10], should be included in **activities and services (such as early years services, education, employment, social and sports/leisure) that enable them to lead a good and meaningful everyday life**. They should have choice and control over the activities in which they participate, facilitated through person-centred care and support plans/ Education, Health and Care (EHC) plans and personal budgets/personal health budgets (see principles 2 and 3) – any restrictions imposed (Ministry of Justice/MAPPA)[11] will need to be considered but should not adversely affect the individual experiencing, where possible and under appropriate supervision, a fulfilling and purposeful everyday life.

1.2 Everyone should have access to **education, training and employment (including supported internships)** which they can access within their local area. To enable this, support providers and multi-disciplinary specialist health and social care teams (see principle 7) should provide training and support to mainstream service staff and/or provide support to individuals and their families/carers that enables them to participate in mainstream services, and to access education and training within local schools and colleges. Commissioners should also seek to ensure that supported employment/ training services meet the needs of this group.

1.3 Everyone should have the opportunity to **develop and maintain good relationships** with people. Commissioners should be mindful of the importance of relationships to keep people safe and well, and should therefore seek to offer good support to families/ carers, friends and others (see principle 4). This should form a key part of people's person-centred care and support plans (see principle 2).

Key actions for health and social care commissioners:

- Strategic learning disability commissioners should work with those that commission and manage mainstream activities/services to find ways to make them accessible, in line with Equality Act duties.
- Operational commissioners will need to work with mainstream services to enable people with a learning disability and/or autism who display behaviour that challenges to be included.
- Local authorities should commission supported employment services that can meet the needs of this group.
- Commissioners should ensure that service specifications are based on person-centred outcomes.

[10] For simplicity, henceforth when we refer to 'everyone' or 'people' in this document, we are referring to this defined group of people (children, young people and adults) unless otherwise stated.

[11] Multi agency public protection arrangements

2. My care and support is person-centred, planned, proactive and coordinated.

> "We know about person-centred planning. Now we want to see the person-centred doing."
>
> **Family carer**

2.1 Local health and care services should develop a **dynamic register** based on sophisticated risk stratification of their local populations. This will enable local services to anticipate and meet the needs of those people with a learning disability and/or autism.

2.2 Everyone should have a **single person centred care and support plan**, incorporating a range of other plans, including behaviour support plans where appropriate, as well as crisis and contingency plans, which they have been involved in drawing up and which they have a copy of. Plans should focus on what is important to the individual. For children and young people up to the age of 25 with a special educational need (SEN), this should take the form of an Education, Health and Care (EHC) plan.

2.3 Everyone should be offered a named **local care and support navigator or keyworker** to coordinate and ensure timely delivery of a wide range of services set out in the person centred care and support plan, working closely with the person and their families/carers where appropriate and ensuring a consistent point of contact.

Key actions for health and social care commissioners:

- Strategic learning disability commissioners should risk stratify their local population of people with a learning disability and/or autism see Annex C.
- Micro-commissioners should ensure that the person they are supporting has a single person-centred care and support plan, not just those on the Care Programme Approach (CPA).
- Commissioners should ensure that everyone is offered a local care and support navigator or key worker.
- Commissioners should ensure a multi-disciplinary approach to EHC plans, not leaving this only to education.

Relevant guidance and standards:

- NHS England guidance on personalised care and support planning.
- Think Local Act Personal (TLAP) guidance on personalised care and support planning.
- National Institute for Health and Care Excellence (NICE) guidance on challenging behaviour and learning disabilities, section on understanding the risks of developing behaviour that challenges.
- Preparing for adulthood programme, including information and guidance on EHC plans.

3. I have choice and control over how my health and care needs are met.

> "My advocate spoke for me after I told her what I wanted to say. I didn't have the courage to speak myself [in review meeting]."
>
> **Individual with a learning disability**

3.1 Everyone should receive information about their care and support in formats that they can understand and should receive appropriate support to help them communicate, in keeping with the new Accessible Information Standard.

3.2 Individuals, and where appropriate families/carers, should be integral partners in care and support planning discussions (see principle 2). Even where people lack capacity to make specific decisions, they should be involved in care and support planning discussions wherever possible and any decisions taken on their behalf should be made in their best interests. These discussions and the final plan should be person-centred and focused on what is important to the individual. Increasingly, people should expect to be offered a **personal budget, personal health budget, or integrated personal budget** across health and social care, and should have access to information advice and support to help them understand the choices available to them, exercise these choices and to help them plan how to use and manage their budget. Many will already have a right by law to personal budgets or personal health budgets, but commissioners should be rapidly and ambitiously extending this offer beyond rights guaranteed in law.

3.3 At key points in their interaction with health, education and care services, people should have access to different types of **independent advocacy**. In addition to the legal right to advocacy, people should also be offered non-statutory advocacy, which should be available to them either at key transition points and/or for as long as they require at other times in their lives. This will include in preparation for and on leaving a specialist hospital. Both statutory and non-statutory advocacy should be delivered by services that are independent of the organisations providing the person's care and support.

Key actions for health and social care commissioners:

- Commissioners should be planning for, and delivering the offer of, personal budgets, personal health budgets and integrated personal budgets beyond rights guaranteed in law.
- By April 2016, every CCG will be expected to have a 'local offer' for how to expand the use of personal health budgets; this must include people with a learning disability.
- Commissioners should work with the local voluntary sector to consider what additional or different local services are needed to ensure that people with personal budgets have a range of services to choose from.

- Commissioners should be extending the offer of advocacy through investment in non-statutory advocacy services and should ensure statutory and non-statutory advocacy is available to people who are leaving a hospital setting.
- Commissioners should ensure that advocacy services are independent and provided separately from care and support providers

Relevant guidance and standards:

- NHS England's Accessible Information Standard.
- NHS planning guidance, section on Personal Health Budgets : Forward view into action: Planning for 2015/16.
- NHS England's Personal Health Budgets Right to Have guidance.
- TLAP guide to personal health budgets for people with learning disabilities.

4. My family and paid support and care staff get the help they need to support me to live in the community.

> "It is paramount that families get support especially when their child has complex needs. Support rarely arrives until there is a crisis…by which time it's too late to remedy."
>
> **Family carer**

4.1 All families or carers who are providing care and support for people who display behaviour that challenges should be offered **practical and emotional support** and access to **early intervention programmes**, including evidence-based parent training programmes, and other skills training, in line with NICE guidance and which is targeted to meet their specific strengths, challenges and needs.

4.2 All families or carers who are providing care and support for people who display behaviour that challenges should be offered information about a **carers assessment and advocacy support** in their own right, **access to short breaks/respite** suitable for people whose behaviour challenges and which meets their own needs, and support to care for the person from specialist multi-disciplinary health and social care teams (see principle 7).

4.3 **Alternative short term accommodation** (available for a few weeks) should be available to people, as and when it is needed, to be used in times of crisis or potential crisis as a place where they can go for a short period, preventing an avoidable admission into a hospital setting. It might also provide a setting for assessment from teams providing intensive multi-disciplinary health and care support (see principle 7) where that assessment cannot be carried out in the individual's home.

4.4 Everyone who is getting a social care package should have access to paid support and care staff **trained and experienced** in supporting people who display behaviour that challenges, and those who may have come into contact with or are at risk of coming into contact with the criminal justice system. These staff should be able to deliver proactive and reactive strategies to reduce the risk of behaviour that challenges, in line with NICE guidelines.

4.5 Local authorities should use **Market Position Statements** with an explicit focus on people with a learning disability and/or autism. **They should identify a group of preferred providers**, which can demonstrate minimum quality standards and competencies. These providers should be seen as genuine partners of specialist multi-disciplinary health and social care teams (see principles 7 and 8.3) as part of multi-agency working. Commissioners, along with the providers, should develop competency frameworks, such as that provided by Health Education England. These competency frameworks need to include requirements for staff training, for example person-centred approaches, communication and Positive Behaviour Support (PBS), in line with the PBS competency framework.

Key actions for health and social care commissioners:

- Children's and strategic learning disability commissioners should ensure availability of early intervention programmes, including evidence-based parent training programmes.
- Children's and strategic learning disability commissioners should ensure availability of a range of support and training for families and carers.
- Children's and strategic learning disability commissioners should provide flexible and creative short break/respite options.
- Children's and strategic learning disability commissioners should work with their local providers to develop models of alternative short-term accommodation.
- Commissioners should develop a group of social care preferred providers that meet the needs of people with a learning disability and/or autism.
- Local authorities should develop Market Position Statements with an explicit focus on this group.

Relevant guidance and standards

- NICE guidance on challenging behaviour and learning disabilities, sections on parent-training programmes and proactive and reactive strategies.
- Positive Behaviour Support (PBS) competency framework.
- Health Education England's learning disability skills and competency framework.
- Department of Education guidance on short breaks for carers of disabled children.

5. I have a choice about where I live and who I live with.

"I don't want to lose my home again if I go back to hospital."

Individual with autism

"Help people to see what their housing options are and what it really means to them."

Feedback from a discussion forum on housing

5.1 People should be offered a **choice of housing, including small-scale supported living**. This choice may be circumscribed by the Ministry of Justice (MOJ) in some instances if the individual is on an offender pathway. Choice about housing should be offered early in any planning processes (e.g. in transition from childhood to adulthood, or in hospital discharge planning) and should be based on individual need and be an integral component of a person's person-centred care and support plan (see principle 2). Where people live, who they live with, the location, the community and the built environment need to be understood from the individual perspective and at the outset of planning.

5.2 Everyone should be offered **settled accommodation**. This should include exploring home ownership, or ensuring security of tenure.

5.3 Commissioners need to work closely with housing strategy colleagues to ensure that the future needs of this group are understood, considered and planned for strategically and form part of **local housing strategies**.

Actions for health and social care commissioners:

- Commissioners should co-produce local housing solutions leading to security of tenure, that enable people to live as independently as possible, rather than in institutionalised settings
- CCGs could consider allowing individuals with a personal health budget to use some of their budget to contribute to housing costs if this meets a health need and is agreed as part of the individual's care and support plan.
- Strategic commissioners need to work with housing strategy colleagues to ensure strategic housing planning

Relevant guidance and standards:

- Communities and local government guidance on Disabled Facilities Grants

6. I get good care and support from mainstream health services.

> "Professionals working with people with autism and not knowing that autism is a 'triad" of social impairments is a bit like finding a builder who does not know how to mix cement.
>
> **Feedback from people with lived experience**

6.1 Everyone with a learning disability over the age of 14, should be offered an **Annual Health Check**. This is particularly important for those with communication difficulties. Everyone should have **a Health Action Plan**, which identifies how any physical and mental health needs will be met, and this should form an integral component of a person's person-centred care and support plan (see principle 2). Where appropriate it should include a **'Hospital Passport'** to help mainstream NHS services make the reasonable adjustments required by law (including meeting the needs of people who display behaviour that challenges) and ensure equity of health outcomes for people.

6.2 Everyone should expect universal NHS services to employ clearly identified and readily accessible primary and secondary healthcare **'liaison' workers** who have specialist knowledge and specific skills in working with people with a learning disability and/or autism which enable them to advise those services on how to make effective adjustments.

6.3 Everyone should expect **'quality checker'** schemes to be in place ensuring that mainstream services serve them appropriately.

6.4 Everyone should expect mainstream mental health services to regularly audit how effective they are at meeting the needs of people with a learning disability and/or autism. The Green Light Toolkit should be used to both **evaluate services and to agree local actions** to deliver real improvements. In many instances this will require investment in mainstream mental health services (such as Child and Adult Mental Health (CAMHS) Services, Improving Access to Psychological Therapies (IAPT) and services that are helping to deliver against the Crisis Care Concordat). In other instances there will be new initiatives to support mainstream mental health services to make reasonable adjustments to their pathways of care and support, and to improve access to those services.

Actions for health and social care commissioners:

- Health commissioners should ensure that people with a learning disability are offered Annual Health Checks.
- Health commissioners should ensure that everyone has the option of a Health Action Plan, and are promoting the use of Hospital Passports.
- Mental Health commissioners should ensure that the Green Light Toolkit audit is completed annually, and an action plan developed.
- Commissioners should ensure that practices and care and support pathways within mainstream primary and secondary NHS services are 'reasonably adjusted' to meet the needs of this group, in line with Equality Act duties, and are routinely monitoring equality of outcomes.

Relevant guidance and standards:

- Green Light toolkit: reasonable adjustments in mental health services.
- Improving Health and Lives (IHAL) resources on making reasonable adjustments for people who need mental health services and support.
- IHAL Working Together guidance for improving support for people with learning disabilities in hospital.
- NHS England Quality Checkers initiative.
- IAPT Positive Practice guidance for people with learning disabilities.
- 2015 Directions on Annual Health Checks.

7. I can access specialist health and social care support in the community.

> "It is important for them to stick with the person."
>
> **Family carer and a consultant psychiatrist**

7.1 Everyone should have access to **integrated, community-based, specialist multidisciplinary health and social care support for people with a learning disability and/or autism in their community** that is readily accessible, when needed, by children, young people and adults with a learning disability and/or autism, including those who may have come into contact with or are at risk of coming into contact with the criminal justice system (see principle 8). Key functions of this specialist support should include: support to enable people to access mainstream health and social care services, work with mainstream services to develop their ability to deliver individualised reasonable adjustments, support to commissioners in service development and quality monitoring, and the delivery of direct assessment and therapeutic support.

7.2 Specialist support might be provided by a range of services, and often across services (e.g. children's services, Child and Adult Mental Health Services (CAMHS), learning disability CAMHS teams and specialist community learning disability teams). Support should be built around the needs of the individual through a **'Collaborative Care' model, or by combined teams** (e.g. all age, learning disability and autism). Individuals should expect continuity of care and support through close collaboration between services/agencies, including between specialist and mainstream services. Access to and provision of support should be based on need.

7.3 Anyone who requires additional support to prevent or manage a crisis should have access to hands-on **intensive 24/7 multi-disciplinary health and social care support** at home, or in other appropriate community settings, including schools and short break/respite settings. This support should be delivered by members of highly-skilled and experienced multi-disciplinary/agency teams with specialist knowledge in managing behaviours that challenge. The interface between specialist routine multi-disciplinary support services (described above) and this type of intensive support service should be seamless.

Actions for health and social care commissioners:

- Commissioners should ensure the availability of specialist integrated multi-disciplinary health and social care support in the community for people with a learning disability and/or autism, covering all ages.
- Commissioners should ensure this specialist health and social care support includes an intensive 24/7 support function.
- Commissioners should ensure inter-agency collaborative working, including between specialist and mainstream services.

Relevant guidance and standards:

- Mansell Report: Services for people with learning disabilities and challenging behaviour or mental health needs report of a project group.
- Royal College of Psychiatrists: Challenging Behaviour a Unified Approach.

8. If I need it, I get support to stay out of trouble.[12]

> "There was too much focus on mental health reports and a lack of learning disability awareness."
>
> **Individual with a learning disability**

8.1 People who have come into contact with, or may be at risk of coming into contact with the criminal justice system, should have **access to the same services aimed at preventing or reducing anti-social or 'offending' behaviour**[13] **as the rest of the population**. They should expect services (including those provided by youth offending teams, liaison and diversion schemes, as well as troubled family schemes and programmes such as those for drug and alcohol misuse) to identify people with a learning disability and/or autism amongst the people they support, and to make reasonable adjustments so they can effectively support those people. This should be achieved through collaboration with specialist multi-disciplinary health and social care services for people with a learning disability and/or autism (see principle 7, and 8.3 below).

8.2 **Liaison and diversion schemes** should seek to support people through the youth or criminal justice system 'pathway' enabling people to exercise their rights and/or where appropriate, diverting people to appropriate support from health and social care services. Clear pathways for diversion to appropriate health and social care services should be established through local multi-agency protocols.

8.3 When required, people should have access to **specialist multidisciplinary health and social care support for people who have come into contact with or may be at risk of coming into contact with the criminal justice system** (i.e. offering a community forensic function for people with a learning disability and/or autism) including the expertise to manage risks posed to others in the community. The interventions offered by these services will depend on the needs of the individual and the level of risk they pose, from individual and group offence-specific interventions, to specialist assessment and established links with other services aimed at facilitatingappropriate pathways away from the criminal justice system. It is likely that some people will be best served by mainstream forensic services able to work with people with a learning disability and/or autism, and some by specialist multi-disciplinary health and social care services for people with a learning disability and/or autism. In some areas, specialist community forensic learning disability and autism teams or hospital outreach teams work with small numbers of people who pose a more significant risk to others, usually spanning several localities.

[12] A small percentage of people with a (cont.) learning disability and/or autism engage in behaviour that may lead to contact with the criminal justice system, and potentially diversion to a hospital setting. They are included as a distinct group within this service model because their specific needs have not always been recognised; the model presents an opportunity to develop the support and services they may require.

[13] The term 'offending' behaviour is used in this way to encompass those people whose behaviour has brought them into contact with the criminal justice system, even if they have not been convicted of an offence.

Actions for health and social care commissioners:

- Commissioners should ensure that mainstream services aimed at preventing or reducing anti-social or 'offending' behaviour are making reasonable adjustments to meet the needs of people with a learning disability and/or autism, in line with Equality Act duties, and are routinely monitoring equality of outcomes.
- Commissioners should ensure the availability of specialist health and social care support for people with a learning disability and/or autism who may be at risk of or have come into contact with the criminal justice system, offering a community forensic function for this group.

Relevant guidance and standards:

- NHS England - Liaison and Diversion Services.

9. If I am admitted for assessment and treatment in a hospital[14] setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to.

> "Being in hospital helped me understand my mental health needs and I am now living in my own home."
>
> "Sometimes I feel I need a safe place to go every now and again. I stay in hospital for a long time and I have to rebuild my life each time."
>
> **Two individuals with recent experience of being in hospital**

9.1 Everyone who is admitted to a hospital setting for assessment and treatment should expect this to be **integrated into their broader care and support pathway**, with hospitals working closely with community mental health, learning disability/autism and other services, including those providing intensive community and/or forensic support (see principles 7 and 8).

9.2 When people are admitted for assessment and treatment in a hospital setting they should expect support to focus on **proactively encouraging independence and recovery**. Services should seek to minimise patients' length of stay and any admissions should be supported by a clear rationale of planned assessment and treatment with measurable outcomes. Hospitals should not become de facto homes; discharge planning should start from the point of admission - or earlier for a planned admission. Care and treatment should be regularly reviewed, in line with NHS England Care and Treatment Review guidance and CPA requirements. Services should be as close to home as possible and provide care and treatment in the least restrictive setting.

9.3 People who present an immediate risk to those around them and/or to themselves may require admission to a hospital setting when their behaviour and/or mental state is such that assessment and/or treatment is temporarily required that cannot be provided safely and effectively in the community. They should have access to high quality assessment and treatment in **non-secure hospital services** with the clear goal of returning them to live in their home. Sometimes people will be detained under the Mental Health Act if the necessary conditions are met. People with a learning disability and/or autism should be assessed and treated in mainstream inpatient services where this is the most appropriate option. This is likely to be the case for people with a mild learning disability and/or autism who have a mental health problem of a type and severity that warrants inpatient care. Providers should make the reasonable adjustments to enable this (e.g. liaison nurses and collaborative working with learning

(cont.)

[14] 'Hospital' in this context refers to those hospital facilities (registered by the CQC) which are providing mental or behavioural healthcare in England for people with a learning disability and/or autism, or the equivalent organisations in Wales and Scotland for English commissioned patients

disability and/or autism specialists). This might require providers to designate particular wards as suitable for this purpose. People whose learning disability and/or autism is more significant and who require an adapted environment and/or intensive specialist treatment and care should be admitted to a specialist unit if they require inpatient care. These specialist beds should be increasingly co-located within mainstream hospital settings as part of integrated specialist inpatient services, rather than in isolated stand-alone units. With the right support at the right time in the community, use of inpatient services should be rare and only for clearly defined purposes.

9.4 Admission to **secure inpatient services** should only occur when a patient is assessed as posing a significant risk to others. Often they will be detained under Part III of the Mental Health Act ('patients concerned in criminal proceedings or under sentence') and in contact with the criminal justice system, with or without restrictions from the Ministry of Justice. Some patients, however, may be detained in secure settings under Part II of the Mental Health Act where they pose an equivalent level of risk to others and this risk cannot be managed safely in less secure settings. For example, those who have been diverted away from the criminal justice system as a result of criminal justice agencies not taking the case through the courts, or discontinuing proceedings once it is seen that the person is already in hospital. In line with the Mental Health Code of Practice, only patients who require a combination of enhanced physical, procedural and relational security should be placed in secure services.

9.5 Everyone, other than those following diversion or direction from the criminal justice system, should expect a **community (pre-admission) CTR**. In urgent situations where there is not time to convene a CTR then there should be a 'Blue Light' meeting, in line with NHS England policy and guidance. Admissions should always be with a clear stated purpose and set of expected outcomes. In the event of an urgent admission, where a CTR has not been carried out, then this should take place within 10 working days of their admission. After six months they should expect a mandatory CTR. Additionally, at any stage in hospital, should there be concerns about care and treatment, the person themselves, their family, advocate, commissioner or clinical team have a 'right to request' a CTR.

9.6 For all inpatient provision (secure or not) children admitted to hospital should be placed in an environment suitable for their age and must have access to education. For adults, provision of single-sex accommodation is essential.

Actions for health and social care commissioners

- Health commissioners should ensure that hospital admissions are supported by a clear rationale of assessment and treatment, and desired outcomes, and that services are as close to home as possible.
- Micro-commissioners should be working with individuals, families/carers, clinicians and local community services to ensure that the discharge planning process starts from the point of admission, or before.

- Health commissioners should be ensuring the appropriate CTR are taking place and are of a high quality, in line with NHS England policy.
- Commissioners should ensure that support for families and carers are part of any commissioning framework.

Relevant guidance and standards

- NHS England Care and Treatment Review (CTR) guidance.
- NICE guidance on challenging behaviour and learning disabilities.

Services to meet complex and diverse needs

When designing the service commissioners should also take into account their legal duties under the Equality Act 2010 and with regard to reducing health inequalities, their duties under the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities. See further guidance for NHS commissioners on Equality and Health Inequalities legal duties.

Personal Information

Recording and sharing confidential personal information is a vital part of implementing the principles and procedures set out in this document. It should be done with the explicit informed consent of the person the information is about (or when appropriate someone with parental responsibility for them); or, if they lack capacity, an assessment is needed to ensure sharing their information is in their best interests within the framework set out by the Mental Capacity Act 2005 and its Code of Practice. It is particularly important in the context of people with a learning disability and/or autism to make sure that consent is freely given.

The above paragraph above applies to all recording and sharing of confidential personal information for the purposes set out in this and the related documents, including: registers, risk stratification tools, personal health budgets, care plans, communication passports, 'quality checkers' and quality assessment.

However, confidential personal information can be recorded and shared in the public interest to help a child or young person who is or may be at risk of harm, or anyone who is or may be at risk of offending or of suffering harm or loss from offending. In each case the information recorded or shared should be in proportion to the risk.

Clear and robust information sharing protocols or agreements will always be beneficial. However they do not form a legal basis for sharing in themselves. Moreover the absence of a protocol should never be an obstacle to information sharing. Staff should be supported by adequate training and procedures to ensure they share information appropriately and are able to make informed judgements about overriding confidentiality when required.

Annex A
Terminology

Learning disability[15]

Individuals with a learning disability (internationally referred to as individuals with an intellectual disability) are those who have:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a significantly reduced ability to cope independently (impaired adaptive and/or social functioning), and;
- which is apparent before adulthood is reached and has a lasting effect on development.

Each of these three criteria must be met before someone can be said to have a learning disability; Intelligence Quotient (IQ) alone should not be used to determine presence of a learning disability. In terms of intellectual functioning, learning disability is conventionally defined as an IQ score in the region of 70 or below. However, it is not appropriate to use a 'cut off' figure of 70, as the results of a recognised IQ test require skilled interpretation. There should also be significant difficulties in adaptive and/or social functioning, for example in relation to conceptual, social and practical skills (such as language, interpersonal skills and activities of daily living).

The level of support someone needs depends on individual factors, including the severity of their learning disability, which can range from someone with a mild or moderate learning disability to someone with a severe or profound learning disability. The extent and nature of a person's learning disability may be determined by the presence or not of a single major genetic or environmental cause or by multiple factors interacting with educational and social opportunities that facilitate learning and the development of functional and social skills.

Learning disability is different from a specific learning difficulty, such as dyslexia, or a mental health condition.

Autism[16]

Also referred to as Autistic Spectrum Disorder (ASD) or Autistic Spectrum Condition (ASC).

Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how a person makes sense of the world around them.

[15] Adapted from Valuing People, Department of Health, 2001. See: Valuing People – A New Strategy for Learning Disability for the 21st Century

[16] Adapted from Fulfilling and rewarding lives, Department of Health, 2010. See: Fulfilling and rewarding lives: the strategy for adults with autism in England

The three main areas of difficulty, which all people with autism share, are known as the 'triad of impairments'. They are difficulties with:

- social communication (e.g. problems using and understanding verbal and non-verbal language, such as gestures, facial expressions and tone of voice);
- social interaction (e.g. problems in recognising and understanding other people's feelings and managing their own);
- social imagination (e.g. problems in understanding and predicting other people's intentions and behaviour and imagining situations outside their own routine).

Many people with autism may experience some form of sensory sensitivity or under-sensitivity, for example to sounds, touch, tastes, smells, light or colours. People with autism often prefer to have a fixed routine and can find change incredibly difficult to cope with.

Autism is a spectrum condition which means that, while all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives, while others (including those who also have a learning disability) may need more support. It is estimated that around 50% of people with autism also have a learning disability.

Behaviour that challenges

"Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion."[17]

Some people with a learning disability and/or autism display behaviour that challenges. 'Behaviour that challenges' is not a diagnosis and does not in itself imply any understanding as to the causes of the behaviour. The behaviour may be a way for someone to let people know what they want or how they feel, or to try and control what is going on around them, or be a response to physical or mental distress.

A variety of factors are likely to contribute towards the development and escalation of behaviour that challenges, these include (but are not limited to): biological and genetic factors, physical ill-health, impaired communication difficulties, mental ill-health, the impact of poverty and social disadvantage, quality of support and exposure to adversities. Some care and support environments may increase the likelihood of behaviour that challenges, including those with limited opportunities for social interaction and meaningful occupation, lack of choice and sensory input or excessive noise, as well as environments where physical health needs and pain go unrecognised or are not managed.

[17] Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists. (2007). See: Challenging Behaviour: A Unified Approach.

Behaviour that challenges can often result from the interaction between personal and environmental factors, and can include self-injury or physical aggression, severe agitation and extreme withdrawal, as well as behaviours that can result in contact with the criminal justice system – in some cases leading to someone being arrested, charged and convicted of an offence.

Some people may have a long and persistent history of behaviour that challenges, perhaps starting in childhood. In others, it may be highly episodic – arising only under specific circumstances of stress or when the individual has a physical or mental health condition. In others still, it can be traced to a specific life event, such as a bereavement. This means that even if someone does not display behaviour that challenges today, they may do so in the future.

Annex B
Common needs and common shifts in service responses

Children, young people or adults with a learning disability and/or autism who have a mental health condition, such as severe anxiety, depression or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges.

Now

Too often, mental health conditions may not be picked up or appropriately treated at an early stage in the community.

Difficulties accessing appropriate treatment for mental health conditions sometimes mean that people's conditions, once recognised, are so severe or acute that the person needs admission to hospital.

Specialist care and support is too often provided only in reaction to a crisis. The care and support being provided by multiple agencies is typically poorly coordinated and not joined up.

People often feel they have little or no control or choice over the nature of their care and support and are often excluded from mainstream services/activities.

In the future

There is better and earlier identification and treatment of mental health conditions in the community, including through reasonable adjustments to mainstream health services.

Care and support is more proactive, planned and coordinated; there is multi-agency person-centred planning to meet mental health needs resulting in a person-centred care and support plan; planning takes place in partnership with individuals and families/carers who have more choice and control.

People have the support of a local care and support navigator (or keyworker) who is responsible for coordinating and ensuring delivery of their plan.

Care and support is focused on promoting mental health and wellbeing. People have access to activities and services within the community; they have opportunities to learn new skills and have new experiences, and are supported to develop and maintain relationships.

Where a person needs to be admitted to hospital for a mental health condition, it will be for no longer than is necessary and based on a clear treatment plan; it will be form part of an integrated care and support pathway of mental health support that spans hospital and community.

Children, young people or adults with an (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increased likelihood of displaying behaviour that challenges.

Now

Too often poorly constructed care and support packages fail to fully or adequately meet people's needs.

People may be exposed to living environments that contribute to the development or maintenance of behaviours that challenge. Often the impact of physical health conditions are not fully recognised.

At important points of life transitions, care and support is often poorly coordinated. Foreseeable difficulties are not anticipated and ongoing needs are not fully understood or met immediately following transition.

Specialist care and support may not be readily available to people who are not presenting in acute crisis and there is poor coordination between agencies delivering care and support.

A failure to recognise and meet the person's needs often contributes to families/carers or paid support and care staff struggling to support the individual. This can lead to people being admitted to hospital.

People often struggle to access mainstream activities/services.

In the future

Care and support is highly personalised; there is multi-agency person-centred planning and a proactive approach to the identification/treatment of physical and mental health problems.

Individuals and families/carers are fully involved in the development of their person-centred care and support plans and have more choice and control over what their housing, care and support looks like, including through increased use of personal budgets/personal health budgets.

People have the support of a local care and support navigator (or keyworker) who is responsible for coordinating and ensuring delivery of their plan.

Highly skilled and resilient families/carers and paid support and care staff are able to deliver proactive and reactive strategies for managing behaviour that is challenging, and services are actively supporting and enhancing the knowledge and skills of families/carers and paid support and care staff.

People, and those who support them, will be able to readily access advice and support from specialist multi-disciplinary health and/or social care teams. Specialist support will be provided more intensively and flexibly at times of crisis.

People have access to activities and services within the community (taking into account, where relevant, risks posed to others); they have opportunities to learn new skills and have new experiences, and are supported to develop and maintain relationships.

Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive, aggressive or sexually inappropriate behaviour)

Now

Often, evidence-based interventions that, if delivered at an early age would minimise or reduce the development of challenging or risky behaviours, are not available.

Staff working in social care services may struggle to cope with the person's behaviour or effectively support the person.

Involvement with the criminal justice system (which then struggles to recognise and meet people's needs) can lead to people being admitted to hospital.

Specialist care and support may not be readily available to people who are not presenting in acute crisis.

There is often poor coordination between agencies delivering care and support.

People often struggle to access mainstream activities/services.

In the future

Care and support is more proactive, planned and coordinated; there is multi-agency person-centred planning resulting in a person-centred care and support plan.

Services/agencies are working together to deliver evidence-based interventions, from an early age, and people and families/carers are supported by a local care and support navigator (or keyworker) who is responsible for coordinating and ensuring delivery of their person-centred care and support plan.

People, and those who support them, are able to readily access advice and support from specialist multi-disciplinary health / social care teams and specialist community-based forensic services and are supported to manage risks to others in the community.

There is multi-agency and collaborative working. Liaison and diversion schemes, where appropriate, divert people away from the criminal justice system to appropriate specialist health and social care services or provide support throughout the criminal justice pathway in collaboration with these health and social care partners.

People have access to activities and services within the community (taking into account, where relevant, risks posed to others); they have opportunities to learn new skills and have new experiences, and are supported to develop and maintain relationships.

Children, young people or adults with a learning disability and/or autism, often with lower level support needs, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.

Now

Too often, people may have displayed behaviour that challenged as a child or young adult, but their learning disability, autism or mental health condition was not diagnosed (possibly masked by the multiple nature of the child/family's difficulties).

People may be unknown to/not eligible for support from specialist community teams for people with a learning disability (or equivalent), and yet mainstream services struggle to provide the right support.

The person may commit an offence before being diverted to secure hospital settings (which may be where their learning disability and/or autism is first diagnosed or the point at which they are first known to health and social care services).

The individual may be excluded from programmes to address 'offending 'behaviours or struggle to participate. Services that are not familiar with the combination of learning disability and/or autism with 'offending' behaviour may struggle to meet their needs and to assess and manage risk effectively.

Care and support is too often provided in reaction to a crisis and is fragmented, with the individual having little choice or control.

In the future

Services that are aimed at preventing or reducing anti-social/or 'offending' behaviours are able to meet the needs of people with a learning disability and/or autism, including through support from specialist multi-disciplinary health / social care teams and specialist community-based forensic services.

Adapted programmes are available and local services are competent to deliver them.

Local multi-agency working means that a person's health and social care needs are identified earlier and addressed within ordinary community services/settings.

People, and those who support them, are able to readily access advice and support from specialist multi-disciplinary health / social care teams and specialist community-based forensic services and are supported to manage risk to others in the community.

Care and support is more proactive, planned and coordinated, and the individual has more choice and control over what this looks like.

People have access to activities and services within the community (taking into account, where relevant, risks posed to others); they have opportunities to learn new skills and have new experiences, and are supported to develop and maintain relationships.

Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in inpatient settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

Now

Too many people have been in hospital for very many years (in some cases decades).

Care and support is often delivered to people in this situation in a way that isolates them from friends and family; affords them little or no control over their care and support; is not individualised; and is impersonal.

They will often be excluded from mainstream services/activities.

In the future

People are not effectively 'living' in hospitals.

People are resettled in the community; they have highly personalised packages of care and support, through careful planning with the individual, their family/carers and an independent advocate.

People are supported by an independent advocate to help in the transition from a hospital setting.

Care and support is proactive, planned and coordinated, and the individual has more choice and control over what this looks like, including through increased use of personal budgets/ personal health budgets.

People have the support of a local care and support navigator (or keyworker) who is responsible for coordinating and ensuring delivery of their person-centred care and support plan.

People have access to activities and services within the community (taking into account, where relevant, risks posed to others); they have opportunities to learn new skills and have new experiences, and are supported to develop and maintain relationships.

Annex C
Understanding the local population

Commissioners need to have an understanding of different types of need (see Annex B) in order to ensure the availability of the right sorts of support and services in their area. They will need to establish in one place, who their local people are through increasingly sophisticated risk stratification of their local population.

This needs to be included within the Joint Strategic Needs Assessment's ensuring they are an integral part of the whole system assessments of the current and future health and social care needs of the local community and are informing commissioning decisions. The risk stratification will inform local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities.

The starting point should be a focus on those who are most at risk of inappropriate responses by services.

Commissioners should identify and provide enhanced vigilance and service coordination for people who are displaying behaviours which may result in significant harm to themselves/ others/ the environment, and/or are at risk of abuse/exploitation.

This should include (for children, young people and adults):

- anyone currently in a hospital setting;
- anyone referred for or accessing specialised services for challenging behaviour (e.g. intensive support services, specialist short breaks, special schools, residential care and supported living);
- anyone subject to the provisions of the Mental Health Act or subject to Deprivation of Liberty safeguards;
- anyone with a previous hospital stay (for example, with the last 5 years);
- anyone with involvement with the youth or criminal justice system (for example, within the last 12 months);
- those children in 52 week educational placements;
- those in receipt of NHS Continuing Healthcare (CHC) funding;
- those in receipt of services from youth offending teams (YOT).

This will enable commissioners to start to quantify their populations and establish capacity to meet need.

Commissioners will need to work across commissioning and organisations to improve transparency and accountability across the whole system, being clear about how resources are being used in each area and providing evidence to support collaborative decision making.

Annex D
Service model reference group membership

The reference group was co-chaired by Professor Tony Holland (CBE), Department of Psychiatry, University of Cambridge, and Scott Watkin, from national charity SeeAbility and former national learning disability co-tsar for learning disabilities for the Department of Health.

The reference group was set up to provide expert advice and to bring together perspectives from a range of stakeholders.

Individuals represented:

Dominic Tumelty	Association of Directors of Children's Services (ADCS)
Steve James	Avenues Group
Sam Sly	Centre for Welfare Reform
Viv Cooper	The Challenging Behaviour Foundation
Mark Humble	Darlington Borough Council
Stuart Miller	Department for Education (DfE)
Helen Toker-Lester	Devon Clinical Commissioning Group (CCG)
Daniel Dalton	Hertfordshire Partnership University NHS Foundation Trust
Sue Turner	Improving Health and Lives (IHAL)
Susan Harrison	London Borough of Camden
William Wormell	Ministry of Justice (MOJ)
Mark Lever	The National Autistic Society
Rob Greig	National Development Team for Inclusion (NDTi)
Karen Flood	National Forum of People with a Learning Disability

Vicki Raphael	National Valuing Families Forum
Shaun Clee	NHS Confederation
Michael Mellors	National Institute for Health Care and Excellence (NICE)
Gill Bell	Northumberland Tyne and Wear NHS Foundation Trust
Nick Hindley	Oxford Health, NHS Foundation Trust
Ashok Roy	Royal College of Psychiatry
Jean Riley	People hub
Alison Giraud-Saunders	Policy into Practice
Gyles Glover	Public Health England
Jan Tregelles	Royal Mencap Society
Rhodri Hannan	Sheffield Health and Social Care NHS Foundation Trust
Angela Hassiotis, Susan Harrson	University College London (UCL)
Peter Langdon, Glynis Murphy	University of Kent
Richard Hastings	Independent academic
Karen Dodd	Learning Disability Professional Senate

Transforming Care national delivery partners represented: NHS England, Local Government Association, Association of Directors of Adult Social Services, Department of Health, Care Quality Commission and Health Education England.

Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition

October 2015

Association of Directors of Adult Social Services (ADASS)
Local Government Association (LGA)
NHS England

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Jayne Bentley, Care Bill Implementation and Better Care Fund Project Lead, Blackpool Council
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	20 April 2016

BLACKPOOL BETTER CARE FUND 2016/17

1.0 Purpose of the report:

1.1 To update the Board on the Better Care Fund. To seek approval in principle for the Better Care Fund 2016/17 and to agree arrangements for ongoing monitoring and governance.

2.0 Recommendation(s):

2.1 To note the contents of this update report.

2.2 To agree in principle to the submission of the Better Care Fund Plan 2016/17 to be submitted to NHS England for approval. (Please note that due to the delayed publication of NHS planning templates, the final plan is not available at the time of submitting this report).

2.3 To agree a process for the approval of the final Better Care Fund Plan 2016/17.

2.4 To agree, in principal, for ongoing governance by the Strategic Commissioning Group and the establishment of a Monitoring Group to develop the Better Care Fund during the next period.

2.5 To note that the terms of reference for the Better Care Fund Monitoring Group be submitted to a future meeting of the Health and Wellbeing Board for approval.

3.0 Reasons for recommendation(s):

3.1 The Better Care Fund pooled budget is a statutory requirement under the amended NHS Act 2006, including the requirement to submit plans in accordance with NHS

England's policy framework.

It is anticipated that a pro-active approach to the Better Care Fund through a newly established monitoring group will measure performance against the national conditions, and allow the opportunity for increased integration and effectiveness across health and social care in Blackpool.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None as the submission of a Better Care Fund plan for 2016/17 is a statutory requirement under the amended NHS Act 2006.

4.0 Council Priority:

4.1 The relevant Council Priority is: "Communities Creating stronger communities and increasing resilience."

5.0 Background Information

5.1 The August 2013 Government Spending Review established the Better Care Fund to deliver better outcomes and greater efficiencies through the integration of health and social care. It requires Clinical Commissioning Groups and Councils in every area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation.

5.2 Local partners are required to develop a joint spending plan that is approved by NHS England as a condition of the NHS contribution to the Better Care Fund being released into pooled budgets.

5.3 In developing Better Care Fund plans for 2016/17, local partners are required to develop, and agree through their relevant Health and Wellbeing Board:

- a short, jointly agreed narrative plan including details of how they are addressing the national conditions;
- confirmed funding contributions from each partner organisation including arrangements in relation to funding within the Better Care Fund for specific purposes;
- a scheme level spending plan demonstrating how the fund will be spent;
- quarterly plan figures for the national metrics.

5.4 Local partners are required to confirm mandatory and additional funding contributions. This includes confirmation that individual elements of the funding have been used in accordance with their purpose as set out in the policy framework:

- Disabled Facilities Grant – as in 2015/16 the Disabled Facilities Grant will be allocated through the Better Care Fund;
- Care Act 2014 monies – the Better Care Fund allocation to the Clinical Commissioning Group includes monies to support the implementation of the Care Act 2014 and other policies. This funding is not new but has been uplifted from monies made available through last year's Better Care Fund. The direction from NHS England has been simplified and it is expected that this funding will focus mainly on supporting informal family carers;
- Former Carer's Break Funding – the Better Care Fund includes funds previously earmarked for NHS replacement care so that carers can have a break;
- Reablement funding – as in 2015/16, the Better Care Fund includes NHS funding to maintain current reablement capacity across statutory, community, independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

5.5 Local partners are required to articulate a plan for meeting the following national conditions:

i. Better Care Fund plans to be jointly agreed;
ii. Maintain provision of social care services;
iii. Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings;
iv. Better data sharing between health and social care, based on NHS number;
v. Ensure a joint approach to assessments and care planning, with an accountable professional when integrated packages are funded;
vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
vii. Agreement to invest in NHS commissioned out-of-hospital services;
viii. Agreement on a local action plan to reduce delayed transfers of care and improve patient flow.

5.6 National conditions vii and viii above are new for 2016/17. New condition vii replaces the national payment-for-performance element of the 2015/16 Better Care Fund, linked to delivering a reduction in non-elective admissions activity. NHS England have continued to ring-fence an element of the Better Care Fund, and local areas are expected to consider putting an appropriate proportion of this into a local risk-sharing agreement as part of contingency planning in the event of excess emergency hospital activity. The ring-fenced element of the Better Care Fund in Blackpool is £3,619,475.

5.7 Discussions between Blackpool Council and Blackpool Clinical Commissioning Group have taken place during February and March 2016 to finalise the refresh of the Better Care Fund Plan. The following agreements have been reached:

- Additional monies will be added to the pooled budget as outlined at 9.1.
- The schedule of schemes within the Better Care Fund will remain the same for the 2016/17 plan.
- There will be no additional risk sharing agreement outside of that specified in the existing Section 75 agreement as detailed at 10.1.
- The Strategic Commissioning Group (SCG) will continue to have oversight of the Better Care Fund, through monthly reports and an annual review which will be prepared and submitted to the SCG meeting by the Better Care Fund Lead and Accountant.
- A monitoring group consisting of Blackpool Council and Blackpool Clinical Commissioning Group is to be established following NHS England assurance of the 2016/17 Better Care Fund Plan. This group will:
    - Monitor performance of the Better Care Fund and the schemes within it;
    - Establish a set of Better Care Fund outcomes and map activity against these to ensure effectiveness of the fund;
    - Make recommendations on the future development of the Better Care Fund;
    - Ensure that links are established with other integration work-streams in Blackpool, and across the Fylde Coast and Lancashire footprints, e.g. New Models of Care, Vanguards, Healthier Lancashire;
    - Develop an action plan and risk log for the Better Care Fund;
    - Facilitate consultation and engagement with staff, partner agencies, providers, voluntary and community groups and the public, on any proposed changes to the Better Care Fund;
    - Provide regular updates to the Strategic Commissioning Group and Health and Wellbeing Board.

5.8 A draft narrative plan and planning template were submitted to NHS England on 21 March 2016, and have received the provisional assurance status of 'Approved with Support'. The final plans are currently being developed to meet the requirements to achieve 'Approved' status at the final assurance stage. They will be submitted to NHS England on 25 April 2016 following sign-off by Blackpool Council, Blackpool Clinical Commissioning Group and Blackpool Health and Wellbeing Board. A full schedule of deadlines is attached at Appendix 5c.

5.9 Does the information submitted include any exempt information? No

5.10 **List of Appendices:**

Appendix 5a – Draft 2016/17 Blackpool Better Care Fund Narrative Plan
Appendix 5b – Better Care Fund 1617 Planning Template #2
Appendix 5c – 201617 Better Care Fund submission schedule 040416 v0.2

6.0 Legal considerations:

6.1 The legal framework for the Better Care Fund derives from the NHS Act 2006 (amended by the Care Act 2014), which requires that in each area the Better Care Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with Department of Health (DH) and Department of Communities and Local Government (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.

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 Discussions between Blackpool Council and Blackpool Clinical Commissioning Group have resulted in the following proposal for the refreshed planning template:

- all of the Community Contract, excluding the small Children's Services element, will be included in the Better Care Fund.
- an agreed uplift of 1.1% will be applied to all Clinical Commissioning Group funded schemes based on 2015/16 actuals.
- Blackpool Clinical Commissioning Group are meeting the 2016/17 minimum Better Care Fund contribution of £12,736,932, and making an additional contribution of £1,818,509 to make a total of £14,555,441.
- Blackpool Council contribution increases to £2,651,297, which is made up of the Disabilities Facilities Grant and additional contributions to existing Better Care Fun schemes.

This gives a total pooled budget for 2016/17 of £17,206,738.

10.0 Risk management considerations:

10.1 NHS England has continued to ring-fence an element of the Better Care Fund, and local areas are expected to consider putting an appropriate proportion of this into a local risk-sharing agreement as part of contingency planning in the event of excess emergency hospital activity. The ring-fenced element of the Better Care Fund in Blackpool is £3,619,475.

10.2 This has been discussed locally, and it has been agreed not to introduce a risk sharing agreement into the 2016/17 Better Care Fund. The current Section 75 agreement allows commissioners to manage any over and underspends of schemes internally. These will continue to be raised to the Strategic Commissioning Group as part of monthly/quarterly monitoring, to ensure that all parties are aware of their impact, and enable informed decisions on correct action, if appropriate. For jointly commissioned services the % split is as outlined on the expenditure plan.

10.3 The expected outcomes and benefits of the Better Care Fund investment will be measured and performance monitored against the Better Care Fund metrics outlined in the Part 2 of the 2016/17 Planning Template.

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 A programme of engagement was undertaken with patients, service users, the public and local health and social care providers during preparations to write our original Better Care Fund Plan. As there have been no significant changes made during this refresh, this process has not been repeated. However, if decisions are made in-year which affect the content or delivery of the Better Care Fund, a full consultation exercise will be undertaken.

13.0 Background papers:

13.1 None

Blackpool Council
BUILDING A BETTER COMMUNITY FOR ALL

NHS
Blackpool
Clinical Commissioning Group

Appendix 5a Better Care Fund 2016-17

This document brings together the strategic intent and operational planning of how we will deliver Better Care by: integrating reablement and intermediate care; building capacity in the community via the voluntary sector; shifting from a model of dependency and direct provision to supported self-management; co-ordinating care provision, in the community around the care needs and improving mental health and wellbeing for all the people in Blackpool.

Plan Details

Summary of Plan

Local Authority	Blackpool Council
Clinical Commissioning Group	Blackpool CCG
Boundary Differences	Blackpool Council and CCG are co-terminus; however some of the population registered with Blackpool GPs live within Lancashire County Council and vice versa.
Minimum required value of BCF pooled budget 2016/17	£14,577,229
Total agreed value of BCF pooled budget 2016/17	£17,206,738
Date agreed at Health and Wellbeing Board	
Date submitted to NHS England	

Authorisation and signoff

Signed on behalf of Clinical Commissioning Group	Blackpool CCG
By	
Position	
Date	
Signed on behalf of the Council	Blackpool Council
By	
Position	
Date	
Signed on behalf of the Health and Wellbeing Board	Blackpool Health and Wellbeing Board
By Chair of Health and Wellbeing Board	

Date	

1. Local vision for health and social care services

By 2020 we will have created a truly integrated and effective health and social care system that maintains people's health, wellbeing and independence for as long as possible, by providing the highest quality of care.

Our vision is that:

'Together we will have made Blackpool a place where all people can live longer, happier and healthier lives by 2019'

Our vision will be achieved by:

- integrating local health and social care commissioning;
- pooling budgets across organisations;
- creating a neighbourhood/locality model:
    - with co-located, integrated teams;
    - based around groups of GP practices;
    - coordinating out-of-hospital and community health and social care;
- ensuring we have a thriving hospital providing appropriate in-hospital care when needed.

Our vision derives from the bold ambition set out in our Health and Wellbeing Board's Joint Health and Wellbeing Strategy 2013-15, which seeks to make **Blackpool a place where ALL people can live long, happy and healthy lives**. The strategy outlines a process of thinking differently and a framework for the future commissioning of health, social care and broader wellbeing services which will be more focused, better coordinated and provided closer to home. The strategy focuses on three interdependent themes of **healthy lifestyles**, **health and social care** and **wider determinants of health**. Each theme is comprised of specific priority areas which the Board has determined it can most influence and effect as a partnership. Underpinning the strategy are four cross cutting themes, which reinforce the aims and ambition set out in our BCF plan:

1. **Safeguards and protects the most vulnerable**
   Ensure all agencies work together to prevent harm and to identify and protect children and adults living in abusive and neglectful situations.
2. **Integrate services**
   Maximise opportunities and outcomes by drawing together existing resources and aligning expertise.
3. **Focuses on prevention, early intervention and self-care**
   Help people to live well and prevent illness, by empowering them to take better care of themselves and people they know.
4. **Increases/improves choice and control**
   Put people at the centre of how services are delivered by making sure health and social care services can be accessed easily, in a timely way, and see that they are fair.

The aims and objectives for BCF are shared across Blackpool Council and Blackpool CCG. The Council's Business Plan 2015-20 runs in parallel with the current Joint Health and Wellbeing Strategy and features two priorities:

1. **The economy – Maximising growth and opportunity across Blackpool.**
2. **Communities – Creating stronger communities and increasing resilience.**

These priorities have been carefully chosen to ensure that the people of Blackpool live fulfilled happy and safe lives. Each theme is underpinned by a series of objectives and those under **Communities** include **improving health and wellbeing, especially for the most disadvantaged** and **safeguarding and protecting the most vulnerable.** These documents have been informed by the data contained in Blackpool's Joint Strategic Needs Assessment.

Planning is currently in progress on Blackpool's Five Year Forward Vision in the form of the Lancashire and South Cumbria Sustainability and Transformation Plan – Healthier Lancashire. Blackpool's BCF will support this through good evidence based practice and existing joint initiatives which are underpinned by a focus on maintaining independence and control through personalisation of care. Our aspiration is that in five years' time, we will have:

- Co-ordinated health and social care focused on the needs of the individual, so that people get appropriate help and support when they need it, where they need it;
- Developed co-located integrated teams, with multi-professional leadership, based around clusters of GP practices coordinating primary, community and social care;
- Enabled integrated teams to have rapid access and direct referral to appropriate specialist services;
- Made better use of technology, including Telecare/Telehealth/Telemedicine
- Shared data and relevant patient records, using the NHS number as primary identifier across health and social care as the norm;
- An accountable lead professional where appropriate;
- A single assessment process and coordinated care and support plan;
- A robust risk stratification tool to identify patients at greatest risk of admission, and intensively case managing these patients;
- Efficient and coordinated partnership working with the Voluntary, Community and Faith Sector, maximizing volunteering, befriending schemes and supporting social network interventions;
- Developed and extended the Making Every Contact Count Framework.

By 2019, services in Blackpool will be radically different. Health and social care services will be coordinated around the needs of the patient/service user to maximise efficiency and avoid duplication, with increased emphasis on prevention. Blackpool has already developed some excellent examples of integrated working, which are outlined in our Better Care Fund Plan submitted in September 2014. Alongside these, new models of care are being progressed, facilitated by the BCF.

2. An evidence base supporting the case for change

The key vision shared by health and social care organisations across the Fylde Coast, including Blackpool, is to jointly improve the health and wellbeing of all sections of the population, whilst contributing towards financial stability within the health and social care economy. The Fylde Coast health and social care economy recognises that continuing to deliver more care in its current form will not make the required step change improvements in quality of care provision and clinical outcomes that the local population requires. The five year strategic plans of the various organisations within the Fylde Coast health and social care economy all identify this case for change, with key issues being:

- An increasing population, particularly those aged over 60;
- Significant levels of deprivation;
- Significant health inequalities;
- Low life expectancy;
- High prevalence of long term conditions;
- High prevalence of negative lifestyle choices;
- Significantly high utilisation of urgent and emergency healthcare services (~7% growth in non-elective medical admissions in 2014/15 compared with the previous year).

The stakeholders from the various organisations within the Fylde Coast health and social care economy have established agreement through the Fylde Coast Commissioning Advisory Board to design and implement a range of patient centric models of care which aim to address these key issues. Initially, this was based on evidence from other global health economies, as demonstrated in analysis undertaken by Oliver Wyman, which showed that new models of care could drive improved outcomes and quality through proactive, integrated service provision. The three models of care reviewed in the analysis were Extensivist, Enhanced Primary Care, and Episodic Care. Using examples of the implementation of these models of care in the USA, the Oliver Wyman team identified the possible impact within the Fylde Coast health and social care economy.

The two Fylde Coast Clinical Commissioning Groups (CCGs) – Blackpool and Fylde & Wyre – and Blackpool Teaching Hospitals NHS Foundation Trust worked with the Oliver Wyman team to examine the possible opportunities for implementation across the Fylde Coast, including the possible costs and financial benefits. This resulted in the development of the document *'Delivering Proactive Primary Care Across the Fylde Coast and Lancashire in 2014/15'* (Appendix A) which describes the analysis undertaken and the identification of a new primary care orientated care models. This analysis and identification of the new primary care models has subsequently been used to underpin the development of New Models of Care for the Fylde Coast.

The Fylde Coast is reflective of many health systems in the UK and globally, with a substantial proportion of the healthcare budget used to support relatively few patients, many of whom have multiple long term conditions (LTCs), are elderly or frail, or have complex/negative lifestyle issues. All of these factors result in a high level of demand on health and social care services. The proportion of the population with these factors is predicted to increase further, thus increasing the demand for health and social care services, increasing pressure on budgets and requiring health and social care professionals to consider radically different approaches to delivering effective care.

As shown in Figure 1, 55% of secondary care spend for residents of Blackpool CCG is driven by just 3% (9,700 patients) of the population, of whom 3,700 are aged over 60.

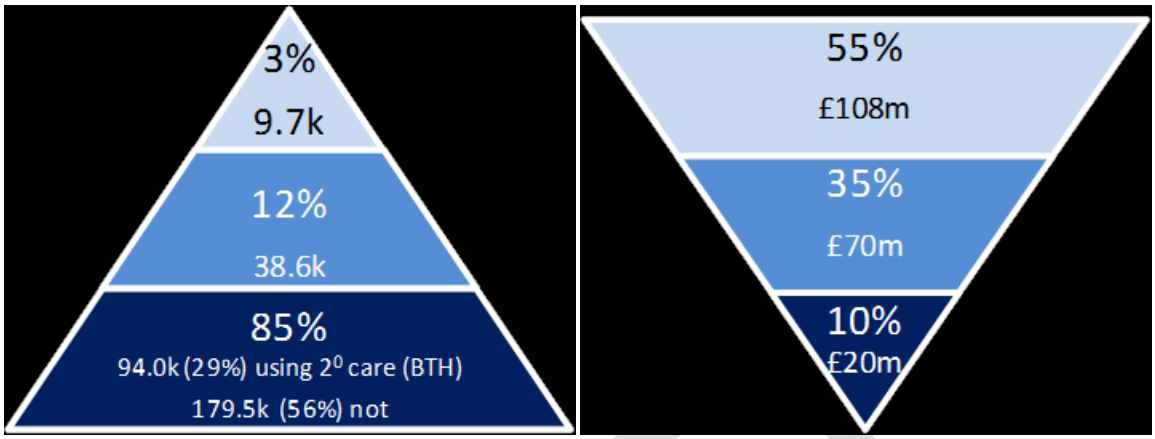

Figure 1: Secondary care spend segmentation for residents of Blackpool CCG

Local stakeholders agree that these proposed new models of care have the potential, when effectively implemented, to have a significant impact on quality of care, clinical outcomes and patient experience, as well as facilitating a reduction in unnecessary demand of urgent and emergency care. Initial analysis suggested that the financial impact of implementing these models of care would be in the range £24m - £30m across the Fylde Coast (for NHS spend), based on the expected reduction in secondary care activity as outlined in Table 1:

	Extensivist	Enhanced Primary Care	Total
Blackpool CCG	£3m to £4m	£10m to 12m	£14m -£16m
Fylde & Wyre CCG	£2m to £3m	£8m to £10m	£10m - £14m
Total	**£6m to £8m**	**£18m to £20m**	**£24m - £30m**

Table 1: Estimated financial impact of implementing new models of care (Oliver Wyman)

3. A co-ordinated and integrated plan of action for delivering that change

Overarching governance and accountability structures
Blackpool CCG led the jointly agreed Fylde Coast Unscheduled Care Strategy (2012) and the Fylde Coast Intermediate Care Review (2013). These included key partners on the commissioning and provider sides with input from external partners. Both identified the need to have better integration of health and social care. From these projects, work is already being delivered in a more co-ordinated and joined up way, providing better care for the citizens of Blackpool.

All key partners are now participating in developing Healthier Lancashire, which will deliver the local STP. Blackpool CCG, Blackpool Council, Fylde & Wyre CCG, Lancashire County Council, Lancashire Care Foundation Trust and Blackpool Teaching Hospitals Trust are working together to ensure transformational change is delivered.

The Health and Wellbeing Board is central to the development and implementation of joined-up health and social care strategies, in particular the Better Care Fund.

Specifics of management and oversight in place to support delivery
The majority of schemes currently within our BCF have been established for some time, and consequently each scheme has its own management and oversight arrangements. For our new models of care, interim processes are in place as set out in *Enhanced Primary Care Service Model Description*.


Enhanced Primary
Care Service Model Bl

We are in the process of setting up a working group to develop our BCF plan over the coming year. The group will be made up of representatives from Blackpool CCG and Blackpool Council, and other services will be invited as and when appropriate. The group will investigate the effectiveness of the schemes within the BCF and monitor expenditure, and will provide regular updates to the Strategic Commissioning Group, which has devolved authority for the HWB. In the event that Project Management activity is required for the BCF, this will be designed by the working group.

Key milestones for delivery in 2016/17
As outlined above, a working group is being established to oversee and develop the BCF project. The group will formulate an action plan and key milestones which will cover ongoing projects, new models of care, effectiveness of the schemes within the BCF and expenditure. A refreshed risk log will also be developed, which will include the existing risks as set out below:

Risk log

No	Description of Risk	Gross Risk Score			Controls and Mitigation	Net Risk Score		
		I[1]	L[2]	GS		I	L	NS
1	Pressure on Council and CCG budgets reduces effectiveness of BCF	4	4	16	The section 75 agreement will require both partners to approve expenditure	4	3	12
2	Operational pressures may restrict community health and social care workforce to deliver transformation	4	4	16	Workforce planning will be part of BCF project management	4	3	12
3	Recruitment and retention of specialised health professionals	5	3	15	We are working with partners and external agencies to attract potential employees with the appropriate skills to deliver BCF	4	3	12
4	Successful diversion of activity away from the acute trust will reduce their income faster than they can shed their costs	5	4	20	Contingency will need to be made available by the CCG for double running costs etc.	5	2	10
5	The BCF schemes fail to divert adequate activity away from acute trust	5	4	20	Discussions on-going with our main provider as to how this risk will be mitigated within the contract negotiation	5	3	15
6	Additional cost pressures following implementation of Care Act	4	4	16	Implications of Care Act duties are evaluated on ongoing basis	4	3	12
7	Ongoing capacity to maintain day to day integrity of the business, safely, whilst delivering change and new models of working	5	3	15	Both organisations will utilise their existing capacity to support the proposed transformation and where possible will identify dedicated resources to oversee, manage and deliver	5	2	10
8	Inadequate level of commissioning support to deliver the agenda	4	3	12	The CCG is working closely to understand the change in resource requirements to deliver the BCF agenda	4	2	8

[1] I = Impact (5=Catastrophic; 4=Major; 3=Moderate; 2=Minor; 1=Insignificant)

[2] L=Likelihood (5=Almost Certain; 4=Likely; 3=More Than Even; 2=Less Than Even; 1=Improbable)

4. Meeting the national conditions

a) Plans to be jointly agreed:

The contents of the 2016/17 BCF have been developed in partnership between Blackpool CCG and Blackpool Council. The plan has been refreshed as follows:

- All of the Community Contract, excluding a small element for Children's Services has been included;
- An agreed uplift of 1.1% has been applied to all Blackpool CCG funded schemes based on 2015/16 actuals.
- Blackpool Council has increased its BCF contributions relating to specific part funded schemes to enable better monitoring and transparency. We are looking to increase our pooled funds even further to reflect the ambition to become fully integrated by 2020.
- Blackpool Council's contribution has been uplifted in line with the increased DFG grant.

The pooled budget total for 2016/17 is £17,206,738, which exceeds the specified minimum.

Any amendments to the original BCF plan have been presented to the Strategic Commissioning Board for agreement on behalf of the HWB. The final submission will be circulated to membership of the SCG and will be presented to the HWB at its meeting on 20th April 2016. This will ensure that agreement is obtained to enable sign off prior to the final submission date.

A programme of engagement was undertaken with patients, service users, the public and local health and social care providers during preparations to write our original BCF Plan. Full details are set out in section 8 of the original BCF. As there have been no significant changes made during this refresh, this process has not been repeated. However, if decisions are made in-year which affect the content or delivery of the BCF, a full consultation exercise will be undertaken.

Blackpool Council and Blackpool Coastal Housing have signed a joint protocol with health providers. This sets out integrated working pathways and aims to achieve improved outcomes.

b) Maintain provision of social care services

In line with the Care Act 2014, Blackpool Council provides adult social care and support to individuals who are unable to achieve two or more specified outcomes, and whose wellbeing is significantly impacted by being unable to do so. Support is also provided to carers who are unable to achieve one or more specified outcomes, to enable them to continue in their caring role. Blackpool Council also has a duty to provide, where appropriate, care and support to those who have been, or are at risk of being, exposed to abuse and/or neglect. The implementation of the Care Act 2014 has seen an increase in the number of assessments and carers assessments, and subsequently reviews, being undertaken by Blackpool Council. With the focus on maintaining people's independence and maximising their wellbeing, Blackpool Council also has a duty to promote prevention and to reduce and/or delay the need for formal care and support services. As well as being an inherent element of the assessment, review and Safeguarding Adults processes, the universal information and advice service required by the Care Act 2014 is enabling those who can to maintain their own independence and wellbeing.

It has been agreed that those social care services that are evidence-based, that meet the BCF vision and deliver the improved outcomes set out in our original BCF plan, will be protected. These schemes are restricted to and listed as expenditure schemes in the 2016/17 planning template. The schemes and details of finances within this plan are built on the principles of integration and joint working. While Blackpool Council continues to face unprecedented reductions in its funding, there will also need to be savings to CCG budgets to facilitate the necessary investment. The BCF offers the opportunity to develop existing programmes of joint

working, and to foster integration between health, adult social care and other partners including housing. The joint commissioners recognise that there are risks and challenges attached to the BCF, and this plan recognises that these risks are shared.

Disabled Facilities Grant – this element of the BCF will be used to fund technologies to support people in their own homes, and to facilitate a joined-up approach to improving outcomes across health, social care and housing. The council is liaising with Housing authority representatives to develop the DFG spend plan for 2016-17 incorporating the increased allocation, once agreed this will be approved as part of the Better Care Fund pooled budget with other partners at the Health & Wellbeing Board.

Carers (including Care Act 2014 monies) – We currently fund £300,000 for day care for people living with dementia, to provide respite for their carers. Additional funding in this year's BCF plan of £126,000 covers:

- Flexible breaks for carers, e.g. joining a gym, pamper sessions, taking up a hobby or training course, going on holiday.
- Support for carers to ensure that their caring role is appropriate and sustainable.
- Support for carers in their own right to maintain their health and maximise their wellbeing.

Supporting carers contribute to reducing non elective admissions to hospital, and long term admissions to residential settings. Our aim is to ensure that their caring role is sustainable and that the person they care for can remain living in the community. It can also be expected that supporting carers will contribute to the reduction in delayed transfers of care.

Reablement – Elements of the BCF will maintain current reablement capacity and community health services through services aimed at enabling people to regain their independence.

Blackpool Council and Blackpool CCG have several existing integrated care pathways, aligned to a focus on promoting independence and supporting people in the community, rather than in hospital or residential care settings. Our multi-disciplinary Rapid Response Teams will continue to provide 7 day services to prevent admission where possible, and to facilitate timely discharge where this has been unavoidable. Similarly the Hospital Discharge Teams ensure that discharges are effectively planned to promote a successful return to the community. These schemes are being further developed under the BCF alongside the Extensive and Enhanced Primary Care models, which will place adult social care within multi-disciplinary neighbourhood teams delivering person-centred, preventative care and support to those people most at risk of losing their independence.

c) 7-day services

A number of services have already been established to support this commitment such as the Rapid Response Nursing Service and Rapid Response Plus. Both have direct access to Council funded short term intensive domiciliary support 7 days per week. Other services such as our residential intermediate care facilities are already 7-day services. Partners are committed to developing integrated 7-day services which support people to be discharged and prevent unnecessary admissions to hospital at weekends. The intention is to establish integrated working practices across health and social care by further widening direct access by health professionals, as part of the integrated model of case management, to the full range of social care services which prevent admissions and support discharge. This will improve patient experience by reducing the number of hand-overs and will create efficiencies by eliminating duplication of assessments. There will also be work with providers of services such as

reablement, rehabilitation beds and recuperation beds to ensure their readiness to accept referrals 7 days per week.

Services will be improved to provide more responsive and patient-centred delivery seven days a week. We are collecting data about the potential to increase in deflections to primary care and increase deflections to 20% during the hours that an additional nurse is on duty. Patients will be diverted away from the emergency floor by offering clinical triage and treatment alternatives, providing better patient experience and care closer to home.

d) Data sharing

Blackpool Council participates regularly in the Lancashire and Cumbria Information Sharing Gateway Group that includes representatives from across the NHS, Police and Local Authorities. The group has actively been involved in developing a system to improve processes around the creation and sign off of information sharing agreements. This will be enhanced by the rollout of the Lancashire and Cumbria Information Sharing Gateway Portal which will provide secure, online information sharing agreements that have agreed assurance between the organisations, have been reviewed by the SIRO and Caldicott guardian, and have agreed review periods electronically implemented. All Social Care Staff have access to an e-learning course specifically designed for social care information sharing, and all complete the mandatory courses on Data Protection and ICT Security. The Council is fully compliant with PSN Code of Connection and IG toolkit working towards Level3.

Adult social care teams follow the principles of Caldicott and Caldicott 2, and the majority of their policies unique to their area of the business contain controls to reinforce this. We recognise that there are some areas for improvement and we are working to facilitate this. This is reflected in our IG Toolkit submission. At the point at which we obtain data from our clients we endeavour to ensure they understand how their data is being used. We do this via leaflets, personal explanations, open policies published on our website, when appropriate we raise awareness through campaigns.

We currently have about 95% coverage on NHS numbers for open cases and we are in the process of including NHS numbers on standard documentation within our Social System. The NHS number is currently populated via the batch tracing service. Health personnel already use the NHS number as their primary identifier, and social care teams are being encouraged to use it in all communication with health.

We are pursuing open API and are currently exploring how we can link our Corelogic Social Care System with LPRES (Lancashire Patient Records Exchange) through an infinity domain

We are currently exploring how both health and social care informatics teams can work together to improve Business Intelligence and informatics for risk stratification and predicative analysis.

e) Joint assessment and accountable lead professional

Blackpool already uses a locally developed and tested risk stratification tool based on health and social care using a joint process to assess risk, plan care and allocate a lead professional. This cohort are then reviewed with their lead clinician and a care plan is completed which can be referred to at any time in or out of hours. The care plans are available to the out of hours triage service and the acute trust. The responsible GP will identify a lead accountable professional in each case.

There is a risk stratification tool (Combined predictive model) available to all NHS Blackpool practices to identify all patients at high risk of admission (vulnerable elderly and those with complex needs). At CCG level (Sept 14), there are 8,500 individuals identified as being at high and very high risk of admission:

Very high risk (0-0.5%) = 863
High risk (0.55%-5%) = 7699.

Fylde Coast Medical Services provide the care co-ordination (single point of access) for patients identified in the top 2% with a care plan – 1505 (17.5%) in place.

There is a national enhanced service in place to support GP's in risk stratification and proactive care designed to improve quality of care for frail elderly and other patients with complex needs (includes dementia and Mental Health). 2% of the registered list will be enrolled onto proactive care plans. In addition, there is a local GP+ scheme which focusses outcomes for individuals with COPD, end of life and risk of admission between 2-5%. Practices are also supported with tools to identify individuals with risk factors who may require management review to optimise treatment. The GP plus scheme also provides indicative outcomes to increase care plans for COPD patients. The national enhanced service also includes people with mental health conditions.

In response to the National Dementia Strategy, CCGs across Lancashire have jointly commissioned Lancashire Care NHS Foundation Trust to provide a dedicated 'dementia gap team' to address the diagnostic gap. The team use GP clinical systems to gather information and record their findings.

f) Consequential impact of changes

A full programme of engagement was undertaken during the planning for Blackpool's 15/16 BCF plan, including discussions with providers who may be affected by the plans. As there have been no significant changes to Blackpool's BCF plan for 2016/17, this exercise has not been repeated. However, it is the intention of Blackpool Council and Blackpool CCG to engage full with all partners, including providers, in the development of our BCF during 2016. This will include providers of services to people with physical disabilities and mental health conditions, as well as the public, patients and service users.

The BCF 2016/17 is aligned with CCG operating plans and provider plans.

g) Investment in NHS commissioned out of hospital services

Several schemes within our Better Care Fund schedule are NHS commissioned out of hospital services, which continue to limit non-elective admissions. As outlined in 5) below, there is local agreement that we will not introduce a risk sharing agreement in relation to these.

h) Local action plan to reduce delayed transfers of care

Blackpool's ongoing action plans for DTOC are attached.

BCCG Delayed Transfers of Care acti

LCFT Remedial Action Plan Version 2.docx

5) Financial risk sharing and contingency

This has been discussed locally, and it has been agreed not to introduce a risk sharing agreement into the 2016/17 BCF. The current section 75 agreement allows commissioners to manage any over and underspends of schemes internally. These will continue to be raised to the Strategic Commissioning Group as part of monthly/quarterly monitoring, to ensure that all parties are aware of their impact, and enable informed decisions on correct action, if appropriate. For jointly commissioned services the % split is as outlined on the expenditure plan.

The expected outcomes and benefits of the BCF investment will be measured and performance monitored against the BCF metrics outlined in the Part 2 of the 2016/17 Planning Template.

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Template for BCF submission 2: due on 21 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: Guidance

Overview

The purpose of this template is to collect information from CCGs, local authorities, and Health and Wellbeing Boards (HWBs) in relation to Better Care Fund (BCF) plans for 2016-17. The focus of the collection is on finance and activity information, as well as the national conditions. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government (www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017). This information will be used during the regionally led assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided separately to regional teams, but there will be no centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex 4 of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17', which is published here: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Timetable

The submission and assurance process will follow the following timetable:

• NHS Planning Guidance for 2016-17 released – 22 December 2015
• BCF Allocations published following release of CCG allocations – 09 February 2016
• Annex 4 - BCF Planning Requirements 2016-17 released - 22 February 2016
• BCF Planning Return template, released – 24 February 2016
• First BCF submission by 2pm on 02 March 2016, agreed by CCGs and local authorities, to consist of:
  o BCF planning return template
All submissions will need to be sent to DCO teams and copied to the National Team (england.bettercaresupport@nhs.net)
• First stage assurance of planning return template and initial feedback to local areas - 02 to 16 March 2016
• **Second version of the BCF Planning Return template, released (with updated NEA plans) – 9th March**
• **Second submission following assurance and feedback by 2pm on 21 March 2016, to consist of:**
  o High level narrative plan
  o Updated BCF planning return template
• **Second stage assurance of full plans and feedback to local areas - 21 March to 13 April 2016**
• BCF plans finalised and signed off by Health and Wellbeing Boards in April, and submitted 2pm on 25 April 2016
This should be read alongside the timetable on page of page 15 of Annex 4 - BCF Planning Requirements.

Introduction

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

Data needs inputting in the cell
Pre-populated cell

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

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

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.
The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'.
The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.

Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please **enter the following information:**
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area.

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 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information:**
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

On this tab please **enter the following information:**

- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure.
- Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below.

- Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.

- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

4. HWB Expenditure plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please **enter the following information:**

- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme)

This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

On this tab please **enter the following information:**

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)
- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

5b. HWB Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the “Technical Definitions” and the “Supplementary Technical Definitions” at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion.

On this tab please **enter the following information:**

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

CCG - HWB Mapping

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.

Template for BCF submission 2: due on 21 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.Please ensure that all boxes on the checklist tab are green before submission.

Complete Template

1. Cover

	Cell Reference	Complete?	Checker
Health and Well Being Board	C10	☐	Yes
completed by:	C13	☐	Yes
e-mail:	C15	☐	Yes
contact number:	C17	☐	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	☐	Yes
Sheet Completed:			Yes

2. Summary and confirmations

	Cell Reference	Complete?	Checker
Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's)	E37	☐	Yes
Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate please indicate the reason for the variance.	F37	☐	Yes
Total value of funding held as contingency as part of lcoal risk share to ensure value to the NHS	F47	☐	Yes
Sheet Completed:			Yes

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25	☐	Yes
Gross Contribution: £000's	C16 : C25	☐	Yes
Comments (if required)	E16 : E25	☐	N/A
Are any additional CCG Contributions being made? If yes please detail below;	C42	☐	Yes
Additional CCG Contribution: <Please Select CCG>	B45 : B54	☐	Yes
Gross Contribution: £000's	C45 : C54	☐	Yes
Comments (if required)	E45 : E54	☐	N/A
Funding Sources Narrative	B61	☐	N/A
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	C70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	C71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	C72	☐	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	C73	☐	Yes
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? Comments	D70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments	D71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	D72		Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	D73	☐	Yes
Sheet Completed:			Yes

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B266	☐	Yes
Scheme Type (see table below for descriptions)	C17 : C266	☐	Yes
Please specify if 'Scheme Type' is 'other'	D17 : D266	☐	Yes
Area of Spend	E17 : E266	☐	Yes
Please specify if 'Area of Spend' is 'other'	F17 : F266	☐	Yes
Commissioner	G17 : G266	☐	Yes
if Joint % NHS	H17 : H266	☐	Yes
if Joint % LA	I17 : I266	☐	Yes
Provider	J17 : J266	☐	Yes
Source of Funding	K17 : K266	☐	Yes
2016/17 (£000's)	L17 : L266	☐	Yes
New or Existing Scheme	M17 : M266	☐	Yes
Total 15-16 Expenditure (£) (if existing scheme)	N17 : N266	☐	Yes
Sheet Completed:			Yes

5. HWB Metrics

	Cell Reference	Complete?	Checker
5.1 - Are you planning on any additional quarterly reductions?	E43	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q1	G45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q2	I45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q3	K45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q4	M45	☐	Yes
5.1 - Are you putting in place a local risk sharing agreement on NEA?	E49	☐	Yes
5.1 - Cost of NEA	E54	☐	Yes
5.1 - Comments (if required)	F54	☐	Yes
5.2 - Residential Admissions : Numerator : Forecast 15/16	G69	☐	Yes
5.2 - Residential Admissions : Numerator : Planned 16/17	H69	☐	Yes
5.2 - Comments (if required)	I68	☐	N/A
5.3 - Reablement : Numerator : Forecast 15/16	G82	☐	Yes
5.3 - Reablement : Denominator : Forecast 15/16	G83	☐	Yes
5.3 - Reablement : Numerator : Planned 16/17	H82	☐	Yes
5.3 - Reablement : Denominator : Planned 16/17	H83	☐	Yes
5.3 - Comments (if required)	I81	☐	N/A
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3	K94	☐	Yes
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4	L94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q1	M94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q2	N94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q3	O94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q4	P94	☐	Yes
5.4 - Comments (if required)	Q93	☐	N/A
5.5 - Local Performance Metric	C105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Metric Value	E105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Numerator	E106	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Denominator	E107	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Metric Value	F105	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Numerator	F106	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Denominator	F107	☐	Yes
5.5 - Comments (if required)	G105	☐	N/A
5.6 - Local defined patient experience metric	C117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value	E117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Numerator	E118	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Denominator	E119	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value	F117	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Numerator	F118	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Denominator	F119	☐	Yes
5.6 - Comments (if required)	G117	☐	N/A
Sheet Completed:			Yes

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14	☐	Yes
2) Maintain provision of social care services (not spending)	C15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	C16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number	C17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	C18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21	☐	Yes
1) Plans to be jointly agreed, Comments	D14	☐	Yes
2) Maintain provision of social care services (not spending), Comments	D15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, Comments	D16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional, Comments	D18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments	D19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21	☐	Yes
Sheet Completed:			Yes

Template for BCF submission 2: due on 21 March 2016

Submission 2 Template Changes - Updates from Submission 1 template

Change	Tabs Impacted	
Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool' table corrected to show spend from CCG Minimum Contribution **only.** Please review.	2. Summary and confirmations	
We have increased the number of rows available on the "HWB Expenditure" tab to 250 rows.	4. HWB Expenditure	
The NEA activity values have been updated following the second "16/17 Shared NHS Planning" submission. Please review the impact and amend the additional quarterly reduction value if required.	5. HWB Metrics	5b. HWB Metrics Tool
Q3 15/16 SUS Actual data (mapped from CCG data) is now included. Q1 and Q2 have been updated.	5. HWB Metrics	5b. HWB Metrics Tool
Actual Q3 15/16 DTOC data is now included.	5. HWB Metrics	5b. HWB Metrics Tool
The issue around the incorrect assigning of the number of delayed days for the 11 Health and Well-Being Boards effecting the DTOC rates per 100,000 population has been amended. Please review the impact and amend if required.	5. HWB Metrics	5b. HWB Metrics Tool
Reablement 14/15 actual % has been amended to match published HSCIC data.	5. HWB Metrics	5b. HWB Metrics Tool
Population figures used for 14/15 changed to match the mid-2014 population estimates used in ASCOF, this impacts on DTOC (Q1 - Q3 14/15) and Residential Admissions rates (14/15). Please review the impact and amend if required.	5. HWB Metrics	5b. HWB Metrics Tool
Comments fields have had text wrapped to allow for users to easily review comments fields.	5. HWB Metrics	

Template for BCF submission 2: due on 21 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: 1. Cover Sheet

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. 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 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

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.

It presents a summary of the first BCF submission and a mapped summary of the NEA activity plans received in the second iteration of the "CCG NHS Shared Planning Process".

Health and Well Being Board	**Blackpool**

completed by:	Jayne Bentley
E-Mail:	jayne.bentley@blackpool.gov.uk
Contact Number:	01253-477433
Who has signed off the report on behalf of the Health and Well Being Board:	Karen Smith

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'

	No. of questions answered
1. Cover	5
2. Summary and confirmations	3
3. HWB Funding Sources	13
4. HWB Expenditure Plan	13
5. HWB Metrics	34
6. National Conditions	16

Template for BCF submission 2: due on 21 March 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Blackpool

Data Submission Period:

2016/17

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£2,651,297
Total Minimum CCG Contribution	£12,736,932
Total Additional CCG Contribution	£1,818,509
Total BCF pooled budget for 2016-17	**£17,206,738**

Specific funding requirements for 2016-17	Select a response to the questions in column B
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes

4. HWB Expenditure Plan

Summary of BCF Expenditure

	Expenditure
Acute	£0
Mental Health	£1,017,064
Community Health	£7,689,827
Continuing Care	£225,453
Primary Care	£1,819,800
Social Care	£6,454,593
Other	£0
Total	**£17,206,738**

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
Expenditure	
£6,454,593	n/a

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

	Expenditure
Mental Health	£0
Community Health	£3,707,472
Continuing Care	£225,453
Primary Care	£1,819,800
Social Care	£0
Other	£0
Total	**£5,752,725**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£3,619,475
Total value of NHS commissioned out of hospital services spend from minimum pool	£5,752,725
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	**£2,133,250**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	5,056	4,969	5,183	5,167	20,376
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	5,056	4,969	5,183	5,167	20,376
Additional NEA reduction delivered through the BCF					£0

5.2 Residential Admissions

		Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	872.4

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	90%

5.4 Delayed Transfers of Care

		Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	691.6	691.6	691.6	692.2

5.5 Local performance metric (as described in your BCF 16/17 planning submission 1 return)

	Metric Value Planned 16/17
Implementation of NHS Number in Social Care	95.0

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 1 return)

	Metric Value Planned 16/17
No Metric Provided	0

6. National Conditions

National Conditions For The Better Care Fund 2016-17	Please Select (Yes, No or No - plan in place)
1) Plans to be jointly agreed	Yes
2) Maintain provision of social care services (not spending)	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes
4) Better data sharing between health and social care, based on the NHS number	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes

Template for BCF submission 2: due on 21 March 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Blackpool

Data Submission Period:

2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Local Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Blackpool	£1,840,297	2016/17 DFG allocation
Blackpool	£811,000	The LA has increased its BCF contributions relating to specific part funded schemes to enable better monitoring and transparency.
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
Total Local Authority Contribution	**£2,651,297**	

CCG Minimum Contribution	Gross Contribution
NHS Blackpool CCG	£12,736,932
Total Minimum CCG Contribution	**£12,736,932**

Are any additional CCG Contributions being made? If yes please detail below;	Yes

Additional CCG Contribution	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Blackpool CCG	£1,818,509	The CCG has increased its BCF funding due to combining previous contracts into the BCF. This should improve our ability to
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**£1,818,509**	

Total BCF pooled budget for 2016-17	**£17,206,738**

Funding Contributions Narrative

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Specific funding requirements for 2016-17	Select a response to the questions in column B	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes	
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	

Template for BCF submission 2: due on 21 March 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Blackpool

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

						Expenditure						
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Rollout of care homes support scheme	Improving healthcare services to care homes		Continuing Care		CCG			NHS Community Provider	CCG Minimum Contribution	£225,453	Existing	£223,000
Out of Hospital IV therapy service	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£248,706	Existing	£41,000
Acute Visiting Service	Personalised support/ care at home		Community Health		CCG			Charity/Voluntary Sector	Additional CCG Contribution	£137,496	Existing	£100,000
High Intensity Users	Intermediate care services		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£73,803	Existing	£49,000
Increasing capacity to provide reablement services (CCG £1.6)	Reablement services		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	£303,300	Existing	£300,000
Single Point of access and care co-ordination	Integrated care teams		Community Health		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£101,100	Existing	£100,000
Community Equipment &adaptationsexisting plus (S256)	Intermediate care services		Community Health		Joint	85.0%	15.0%	Local Authority	CCG Minimum Contribution	£945,285	Existing	£935,000
Community Equipment &adaptationsexisting plus (S256)	Intermediate care services		Community Health		Joint	85.0%	15.0%	Local Authority	Local Authority Social Services	£626,000	New	
Vitaline (S256)	Intermediate care services		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	£687,480	Existing	£680,000
Integrated Crisis and Rapid Response (S256)	Integrated care teams		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£567,171	Existing	£561,000
Maintaining Eligibility Criteria (existing(£125k) plus S256)	Personalised support/ care at home		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£1,475,049	Existing	£1,459,000
Reablement Services (S256)	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£590,424	Existing	£584,000
Bed Based Intermediate Care Services (from CCG £1.6m plus S256)	Intermediate care services		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	£597,501	Existing	£591,000
Early Supported hospital Discharge (CCG £1.6m plus S256)	Intermediate care services		Community Health		Joint	0.0%	100.0%	Local Authority	CCG Minimum Contribution	£468,093	Existing	£463,000
Early Supported hospital Discharge (CCG £1.6m plus S256)	Intermediate care services		Community Health		Joint	0.0%	100.0%	Local Authority	Local Authority Social Services	£58,000	New	
Mental Health Services (S256)	Personalised support/ care at home		Mental Health		Local Authority			Local Authority	CCG Minimum Contribution	£503,478	Existing	£498,000
Mental Health Services (S256)	Personalised support/ care at home		Mental Health		Local Authority			Local Authority	Local Authority Social Services	£103,000	New	
Dementia Services (CCG £1.6m)	Personalised support/ care at home		Mental Health		Local Authority			Local Authority	CCG Minimum Contribution	£245,673	Existing	£243,000
Other Preventative Services (S256)	Intermediate care services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£65,715	Existing	£65,000
Other Preventative Services (S256)	Intermediate care services		Social Care		Local Authority			Local Authority	Local Authority Social Services	£24,000	New	
Carers support workers/grants(from CCG £1.6m)	Support for carers		Community Health		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£126,375	Existing	£125,000
AHP /Nursing Support to ARC (from CCG £1.6m)	Intermediate care services		Community Health		Local Authority			NHS Community Provider	CCG Minimum Contribution	£167,826	Existing	£166,000
Rapid Response (existing plus £1.6m)	7 day working		Community Health		Joint	55.0%	45.0%	NHS Community Provider	CCG Minimum Contribution	£808,800	Existing	£800,000
HD Team (from CCG £1.6m)	Intermediate care services		Community Health		Joint	100.0%	0.0%	NHS Community Provider	CCG Minimum Contribution	£128,397	Existing	£127,000
Hospital Aliveness service (existing)	Personalised support/ care at home		Social Care		Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£73,803	Existing	£71,000
Disabled Facilities and Social Capital Grants	Personalised support/ care at home		Social Care		Local Authority			Local Authority	Local Authority Social Services	£1,840,297	Existing	£1,649,000
Extensive Care Service	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£1,011,000	Existing	£1,000,000
Support Care Act	Personalised support/ care at home		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£606,600	Existing	£600,000
GP Plus Care Scheme	Personalised support/ care at home		Primary Care		CCG			Primary Care	CCG Minimum Contribution	£1,819,800	Existing	£1,800,000
Community schemes aimed at NEL reduction and OOH	Intermediate care services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£303,300	Existing	£1,000,000
GP £5 per head (QIPP investment)	Intermediate care services		Community Health		CCG			Primary Care	CCG Minimum Contribution	£666,603	New	
GP £5 per head (QIPP investment)	Intermediate care services		Community Health		CCG			Primary Care	Additional CCG Contribution	£208,397	New	
Community Equipment &adaptations	Intermediate care services		Community Health		Joint	85.0%	15.0%	Local Authority	Additional CCG Contribution	£22,365	New	
MH Rehab- Gloucester Avenue	Integrated care teams		Mental Health		Local Authority			Local Authority	Additional CCG Contribution	£147,726	New	
Learning Disabilities- Joint funded services	Integrated care teams		Social Care		Local Authority			Local Authority	Additional CCG Contribution	£1,151,246	New	

Template for BCF submission 2: due on 21 March 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Blackpool

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

Contributing CCGs	% CCG registered population that has resident population in Blackpool	% Blackpool resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
			CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Blackpool CCG	87.0%	97.5%	5,703	4,960	5,596	4,867	5,844	5,082	5,829	5,069	22,972	19,978
NHS Fylde & Wyre CCG	2.6%	2.5%	3,769	96	4,016	103	3,953	101	3,830	98	15,568	398
Totals		**100%**	**9,472**	**5,056**	**9,612**	**4,969**	**9,797**	**5,183**	**9,659**	**5,167**	**38,540**	**20,376**

Are you planning on any additional quarterly reductions?	No							
If yes, please complete HWB Quarterly Additional Reduction Figures								
HWB Quarterly Additional Reduction Figure								
HWB NEA Plan (after reduction)								
HWB Quarterly Plan Reduction %								

Are you putting in place a local risk sharing agreement on NEA?	No	
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£3,619,475	
Cost of NEA as used during 15/16 ****	£1,900	Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.
Cost of NEA for 16/17 ****		

Additional NEA reduction delivered through the BCF								
HWB Plan Reduction %								

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 7th March 2016.
** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)
*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx
**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	867.2	902.4	877.1	872.4	Figures submitted are as per SALT sumbission which currently excludes long-term admissions which have resulted from a review of someone in receipt of short-term care.
	Numerator	247	265	253	253	
	Denominator	28,480	28,844	28,844	29,001	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'. Any numerator less than 6 has been supressed in the published data and is therefore showing blank in the numerator and annual rate cells above. These cells will also be blank if an estimate has been used in the published data.

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	78.6%	90.0%	53.2%	90.0%	The forecast for 15/16 is based on discharges from hospital into reablement between October and December 2015 and those who have reached their point of contact by 02/03/16.
	Numerator	75	81	59	81	

	Denominator	100	90	111	90									

*****Any numerator or denominator less than 6 has been supressed in the published data and is therefore showing blank in the cells above. These cells will also be blank if an estimate has been used in the published data.

5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	684.6	689.0	684.6	680.9	599.2	807.3	1190.5	691.6	691.6	691.6	691.6	692.2	Please add comments, if required
	Numerator	770	775	770	765	674	908	1,339	777	777	777	777	777	
	Denominator	112.475	112.475	112.475	112.349	112.475	112.475	112.475	112.349	112.349	112.349	112.349	112.249	

5.5 Local performance metric (as described in your BCF 16/17 planning submission 1 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Implementation of NHS Number in Social Care	Metric Value	95.0	95.0	Please add comments, if required
	Numerator	2,532.0	2,532.0	
	Denominator	2,666.0	2,666.0	

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 1 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 1 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
No Metric Provided	Metric Value	0.0	0.0	Please add comments, if required
	Numerator	0.0	0.0	
	Denominator	0.0	0.0	

Template for BCF submission 2: due on 21 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Blackpool

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.1 HWB NEA Activity

Blackpool Data Source Used - 15/16	SUS				
	Q1	Q2	Q3	Q4	Total
Blackpool 14/15 Baseline (outturn)	5,101	4,853	5,129	5,046	20,129
Blackpool 15/16 Plan	4,870	4,672	4,855	4,698	19,095
Blackpool 15/16 Actual	5,136	4,959			10,095

14/15 baseline and plan data has been taken from the "Better Care Fund Revised Non-Elective targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection" returned by HWB's in July 2015. The Q1 15/16 actual performance has been taken from the "Q1 Better Care Fund data collection" returned by HWB's in August 2015. The Q2 actual performance 15/16 and the Q4 15/16 plan figure have been taken from the "Q2 Better Care Fund data collection" returned by HWB's in November 2015. Actual Q3 and Q4 data is not available at the point of this template being released.

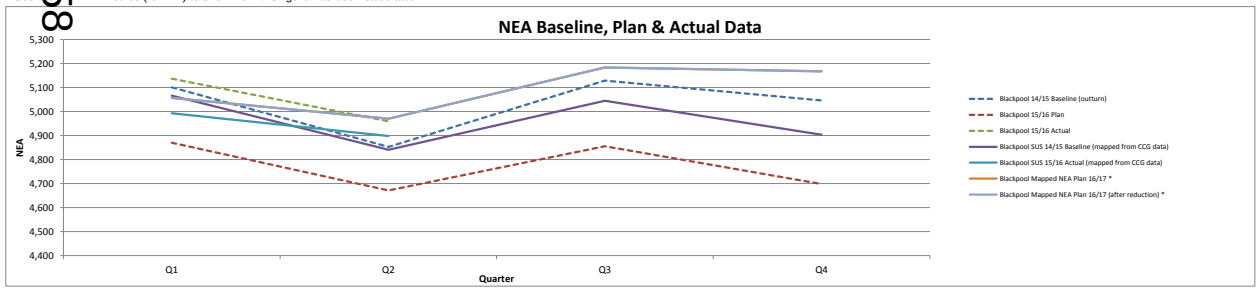
Blackpool SUS 14/15 Baseline (mapped from CCG data)	**5,066**	**4,841**	**5,044**	**4,903**	**19,854**
Blackpool SUS 15/16 Actual (mapped from CCG data)	4,993	4,897	5,115		15,006
Blackpool SUS 15/16 FOT (mapped from CCG data)					20,103

SUS 14/15 baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures were mapped from the baseline data supplied to assist the CCGs with the 16/17 shared planning round.

Over the last year the monitoring of non-elective admission (NEA) activity has shifted away from the use of the Monthly Activity Return (MAR) towards the use of Secondary Users Service data (SUS). This has been reflected in the latest planning round where NHS England, Monitor and TDA have worked with CCGs and providers to create a consistent methodology to enable the creation of consistent NEA plans. The SUS CCG mapped data included here has been derived using this methodology. More details on the methodology used to define NEA can be found in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Blackpool Mapped NEA Plan 16/17 *	**5,056**	**4,969**	**5,183**	**5,167**	**20,376**
Blackpool Mapped NEA Plan 16/17 (after reduction) *	**5,056**	**4,969**	**5,183**	**5,167**	**20,376**

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



Template for BCF submission 2: due on 21 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Blackpool

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

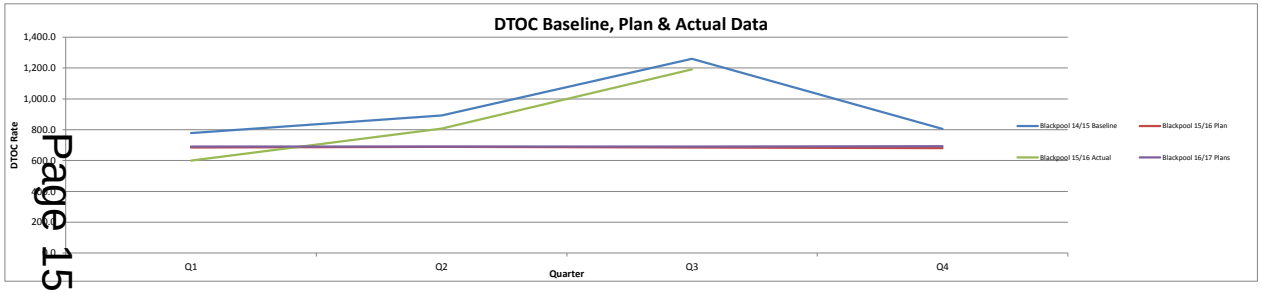
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.4 Delayed Transfers of Care

	Q1	Q2	Q3	Q4
Blackpool 14/15 Baseline	778.0	892.6	1,259.7	804.6
Blackpool 15/16 Plan	684.6	689.0	684.6	680.9
Blackpool 15/16 Actual	599.2	807.3	1,190.5	

Delayed Transfers Of Care numerator data for baseline and actual performance has been sourced from the monthly DTOC return found here http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/. Actual Q4 data is not available at the point of this template being released.

Blackpool 16/17 Plans	**691.6**	**691.6**	**691.6**	**692.2**



Template for BCF submission 2: due on 21 March 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Blackpool

Data Submission Period:

2016/17

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	Yes	
2) Maintain provision of social care services (not spending)	Yes	
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	
4) Better data sharing between health and social care, based on the NHS number	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	

CCG to Health and Well-Being Board Mapping

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	89.7%	88.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.2%	0.4%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.1%	2.9%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.9%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	0.8%	0.5%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	08H	NHS Islington CCG	0.1%	0.0%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.4%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.3%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	94.0%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.7%
E09000004	Bexley	07N	NHS Bexley CCG	93.6%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.5%	1.6%
E09000004	Bexley	08A	NHS Greenwich CCG	7.7%	8.9%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	92.0%	57.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.9%	20.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	2.9%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.1%	18.6%
E08000025	Birmingham	05P	NHS Solihull CCG	15.0%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	87.0%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.6%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.3%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.7%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.8%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.2%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.8%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.7%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	21.5%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.8%	58.4%
E08000032	Bradford	02T	NHS Calderdale CCG	0.1%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.1%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.0%	2.1%
E09000005	Brent	07P	NHS Brent CCG	89.6%	87.2%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.7%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.6%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.2%	0.1%
E09000005	Brent	08E	NHS Harrow CCG	5.7%	3.9%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.4%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.2%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.7%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.8%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.9%	95.3%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.0%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.2%	35.0%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.1%	59.9%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.5%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.2%	0.6%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.8%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%
E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%

E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.3%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.1%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01M	NHS North Manchester CCG	2.0%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.8%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.6%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.4%	0.4%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.8%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.1%	96.6%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.9%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.1%	0.2%
E09000007	Camden	07P	NHS Brent CCG	1.5%	2.2%
E09000007	Camden	07R	NHS Camden CCG	84.6%	88.4%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	6.0%	5.1%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.4%	3.2%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.1%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.1%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.2%	0.5%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.4%	2.0%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.3%	50.6%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.3%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	2.0%	1.3%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.8%	69.4%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.2%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	0.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.9%	74.1%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.1%
E09000001	City of London	08Q	NHS Southwark CCG	0.0%	0.1%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.8%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.4%	53.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	45.7%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.0%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.5%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.6%	93.7%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.7%	2.6%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.4%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Lancashire North CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.3%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.1%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.1%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.2%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.2%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	1.9%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.3%	36.0%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.2%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.0%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.1%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.0%	80.5%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.7%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.4%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.2%	0.5%

E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.3%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.1%
E10000009	Dorset	11J	NHS Dorset CCG	52.7%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.2%	0.5%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.9%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.6%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000009	Ealing	07W	NHS Ealing CCG	86.7%	90.8%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.7%	2.9%
E09000009	Ealing	08E	NHS Harrow CCG	0.3%	0.2%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.6%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	5.0%	3.7%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.2%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.4%	8.0%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.4%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.5%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.7%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.9%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.5%	90.7%
E09000010	Enfield	08D	NHS Haringey CCG	7.8%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.3%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.4%	11.7%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.8%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.2%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.4%
E10000012	Essex	06T	NHS North East Essex CCG	98.7%	22.4%
E10000012	Essex	08N	NHS Redbridge CCG	3.2%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.3%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	39.6%	98.0%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.7%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.2%	4.3%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.6%	89.9%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.1%	4.5%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.6%	94.6%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.1%	3.4%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.7%
E06000006	Halton	01J	NHS Knowsley CCG	0.1%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	0.9%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.3%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.9%	88.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.8%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.6%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.4%	14.6%

E10000014	Hampshire	10X	NHS Southampton CCG	5.5%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.7%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.0%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.5%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.6%
E09000014	Haringey	07R	NHS Camden CCG	0.5%	0.5%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.6%
E09000014	Haringey	08H	NHS Islington CCG	2.3%	1.9%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.7%	5.0%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	90.0%	84.3%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.4%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.7%	1.9%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.1%	0.4%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.6%	99.6%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	4.0%	3.3%
E09000016	Havering	08F	NHS Havering CCG	92.0%	95.9%
E09000016	Havering	08M	NHS Newham CCG	0.0%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.5%	0.6%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.1%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.8%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.3%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.9%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.7%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	90.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%
E09000018	Hounslow	07W	NHS Ealing CCG	5.8%	8.0%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.0%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.3%	3.6%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.4%	4.9%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.4%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.2%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.7%
E09000019	Islington	08H	NHS Islington CCG	89.8%	89.0%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.1%	5.1%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	0.9%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	64.1%	93.2%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.1%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.8%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	13.0%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.3%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.5%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.6%	98.5%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.8%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.0%	1.2%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.5%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.8%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.6%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.8%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	99.0%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.1%	0.9%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.9%	88.2%

E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.9%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	86.8%	92.7%
E09000022	Lambeth	08R	NHS Merton CCG	1.2%	0.7%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.0%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	98.9%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.4%	11.9%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Lancashire North CCG	99.8%	12.8%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.0%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.1%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.3%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.5%	31.9%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	42.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.5%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.5%	2.2%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.2%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.6%	2.6%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.3%	40.1%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.7%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.6%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.7%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.3%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.2%	2.0%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.2%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	92.1%	92.5%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.7%	3.7%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.1%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.4%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.6%	19.5%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.2%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.8%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.3%	96.2%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.2%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	00W	NHS Central Manchester CCG	93.7%	36.9%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01M	NHS North Manchester CCG	85.1%	30.3%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01N	NHS South Manchester CCG	93.9%	28.2%
E08000003	Manchester	01W	NHS Stockport CCG	1.5%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.3%	1.8%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.8%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	0.9%	1.4%
E09000024	Merton	08R	NHS Merton CCG	87.7%	81.5%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.5%	10.5%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.0%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.4%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.0%	95.0%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.2%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%

E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.9%	97.9%
E09000025	Newham	08N	NHS Redbridge CCG	0.2%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.5%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.1%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.8%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.7%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.8%	25.3%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.7%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.1%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.1%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.7%	1.6%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.1%	96.4%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.3%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.7%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.3%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%
E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.6%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	85.0%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.7%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	94.8%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.1%
E06000018	Nottingham	04M	NHS Nottingham West CCG	5.7%	1.6%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.1%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.5%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.7%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.8%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.1%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.1%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.5%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.4%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	89.3%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.5%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.4%	1.3%
E08000004	Oldham	01M	NHS North Manchester CCG	2.6%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.7%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.2%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.6%	96.1%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.2%	3.9%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.3%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%

E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.2%	36.6%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.9%	60.1%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.9%	0.8%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.7%	99.0%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	5.0%	7.1%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	92.2%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.5%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.6%
E08000005	Rochdale	01M	NHS North Manchester CCG	1.8%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.8%	0.9%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.7%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.6%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	12.0%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	00W	NHS Central Manchester CCG	0.3%	0.3%
E08000006	Salford	01M	NHS North Manchester CCG	2.1%	1.7%
E08000006	Salford	01G	NHS Salford CCG	93.9%	95.1%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.1%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.2%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	2.8%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.8%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.3%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.6%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.2%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.9%
E08000014	Sefton	01V	NHS Southport and Formby CCG	97.0%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.5%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.5%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.2%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.7%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.2%	6.7%
E06000039	Slough	10T	NHS Slough CCG	96.6%	92.9%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	2.0%	6.8%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.3%	0.3%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05P	NHS Solihull CCG	83.8%	91.7%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.5%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.4%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	4.7%	8.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.0%	89.4%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.1%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.3%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.5%	99.6%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.4%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.6%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	07R	NHS Camden CCG	0.5%	0.4%

E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.0%	1.3%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.6%
E09000028	Southwark	08L	NHS Lewisham CCG	1.9%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.5%	88.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.0%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.5%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.6%	1.1%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	91.9%	14.5%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.1%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.8%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	00W	NHS Central Manchester CCG	0.7%	0.6%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	01N	NHS South Manchester CCG	2.9%	1.7%
E08000007	Stockport	01W	NHS Stockport CCG	95.2%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.3%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.8%	98.7%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.3%	0.5%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.5%	16.5%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.3%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.2%	0.4%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.0%	29.6%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.7%	0.7%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.3%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.2%
E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.6%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.5%	0.1%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.2%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.5%	29.6%
E10000030	Surrey	08P	NHS Richmond CCG	0.5%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.9%
E10000030	Surrey	10C	NHS Surrey Heath CCG	99.0%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	7.7%	1.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.3%	3.2%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.2%	6.5%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	86.0%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.1%	0.2%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.3%	98.4%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.6%	1.4%
E08000008	Tameside	00W	NHS Central Manchester CCG	0.5%	0.5%
E08000008	Tameside	01M	NHS North Manchester CCG	6.4%	5.5%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.6%	2.1%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	3.0%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.0%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.2%
E06000034	Thurrock	08F	NHS Havering CCG	0.1%	0.2%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.3%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.3%	0.2%

E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.8%	0.8%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.7%
E08000009	Trafford	00W	NHS Central Manchester CCG	4.7%	4.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	01N	NHS South Manchester CCG	3.2%	2.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.3%	93.2%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.6%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.7%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.4%	90.7%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.3%	1.2%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.1%	1.5%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.8%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	2.7%	2.9%
E09000032	Wandsworth	08R	NHS Merton CCG	3.0%	1.8%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.8%	93.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.5%	0.3%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.1%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.6%	21.4%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.8%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.1%	66.2%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.7%	23.7%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	9.1%	7.6%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.6%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.2%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.5%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	2.9%	3.1%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	81.6%	71.1%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.5%	23.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.1%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	1.1%	0.8%
E08000010	Wigan	01X	NHS St Helens CCG	3.9%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.7%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.5%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.6%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.9%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.0%	0.5%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.1%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	97.0%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.9%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.5%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.9%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.2%	1.2%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.7%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.1%	0.0%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.5%
E06000041	Wokingham	10W	NHS South Reading CCG	11.1%	9.0%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.9%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.7%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.9%	4.0%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.7%	92.7%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.5%	0.6%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.6%	1.1%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	48.8%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.5%	18.8%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.4%	99.9%

Deadline	Activity	Who by	Details	Notes	✓
All 2016					
2nd March	1st BCF submission (following CCG Operating Plan submission on 8th Feb) consisting of: BCF planning return	Agreed by CCGs and LAs	Submission to be sent to DCO teams and copied to Better Care Support team	Planning guidance published 23/02/16.	**JB 23/02**
7-16th March	Assurance of CCG Operating Plans and BCF plans	Regional assurance & moderation teams			
9th March	Deadline for SCG papers	JB			**JB/LW 9/3**
16th March	SCG Meeting			Papers required by 09/03/16	**JB/LW 16/3**
21st March*	Submission of BCF narrative plan (high level) and revised BCF planning return	LA and CCG	Submission to be sent to DCO teams and copied to Better Care Support team	JB on training 21/03/16. *Local submission deadline 18/03/16.	**JB 18/3**
6th April	Deadline for submission of report to HWBB	JB	For HWBB meeting 20th April	It has been agreed that the report will outline the background and work done so far on 16/17 BCF	
8th April	Assurance status of drafts confirmed	Regional assurance & moderation teams		Date not confirmed by Better Care Support team	
11th April	Feedback to LA/CCG to confirm draft assurance status & actions required	Regional assurance & moderation teams		Date no confirmed by Better Care Support team	
12th April	Planning meeting	JB HL-S	To develop what has been submitted so far	Full requirements not known until final planning templates issued on 14th April	

14th April	Final planning templates published	NHSE/Better Care Support Team			
15th April	Meeting to identify information outstanding and finalise submission	JB/LW HL-S/PC			
19th April	Deadline for SCG papers	JB/LW			
20th April (1.30pm)	Meeting with Councillor Cain to discuss BCF 2016/17 plan and obtain signoff from HWBB	JB/LW			
20th April (3pm)	Health & Wellbeing Board Meeting	JB/LW	To present papers submitted and update on 2016/17 plan	Papers required by 06/04/16	
25th April	Final BCF plans submitted	LA and CCG Signed off by HWB	Submission to be sent to DCO teams and copied to Better Care Support team		
27th April	SCG Meeting	JB/LW			
27th April	Deadline for CLT and CCG Governing Body papers	JB HL-S			
3rd May	Blackpool Council CLT meeting	JB HL-S	Update re 2016/17 BCF submission	Papers required by 27/4/16	
3rd May	CCG Governing Body meeting	HL-S JB	Update re 2016/17 BCF submission	Papers required by 27/4/16	
13th May	Confirmation of final assurance rating	Regional assurance & moderation teams			
25th May	SCG meeting			Papers required by 18/5/16	
24th June	SCG meeting			Papers required by 17/6/16	
30th June	All S75 agreements to be signed and in place	LA and CCG Signed off by SCG and HWB			

Deadlines for local sign-off

Deadlines for submission to NHSE

Completed tasks

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	20 April 2016

HEALTH AND WELLBEING STRATEGY 2016-2019 UPDATE

1.0 Purpose of the report:

1.1 To inform the Board of progress made to develop the Health and Wellbeing Strategy 2016 – 19 and invite discussion on the draft content.

2.0 Recommendation(s):

2.1 To note the progress made to date and comment on the draft document.

2.2 To identify gaps in the strategic approach and suggest options for addressing these.

2.3 To propose activity to be included in the forthcoming action plan.

2.4 To agree a period of consultation on the strategy and to comment on the scope of the consultation exercise.

3.0 Reasons for recommendation(s):

3.1 As part of their statutory duties, Health and Wellbeing Boards are required to produce a strategy setting out their priorities for reducing health inequalities in the local area based on data from the Joint Strategic Needs Assessment. A draft strategy has now been developed for the Board's consideration at the meeting.

Following this meeting, where Board members will have the opportunity to share their views on the strategy, there will be a further period of consultation where views from wider stakeholders and the public will be sought on the content of the strategy.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

There is no alternative as the strategy is a statutory requirement and forms part of the Council's Policy Framework.

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increasing resilience."

5.0 Background Information

5.1 The current Health and Wellbeing Strategy expired at the end of 2015. The Board has previously agreed that a new strategy would be produced based on four new priorities, taking into consideration wider local and national policy developments that are currently unfolding.

5.2 Various stakeholders have been involved in the strategy's development including members of the Strategic Commissioning Group, the Council's Public Health department and the Council's Head of Housing.

5.3 Further consultation is planned with stakeholders including public and third sector service providers and members of the public (should the Board wish this to take place).

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

Appendix 6a – Draft Health and Wellbeing Strategy 2016 – 19

6.0 Legal considerations:

6.1 There is a statutory requirement for Health and Wellbeing Boards to produce a strategy as part of the Health and Social Care Act 2012.

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 An Equality Impact Assessment will be carried out once a draft action plan has been developed; however the purpose of the strategy is to set out a plan to reduce health inequalities in Blackpool therefore consideration has been given to the needs of specific groups throughout the process to date.

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 This is referred to in background information.

13.0 Background papers:

13.1 None

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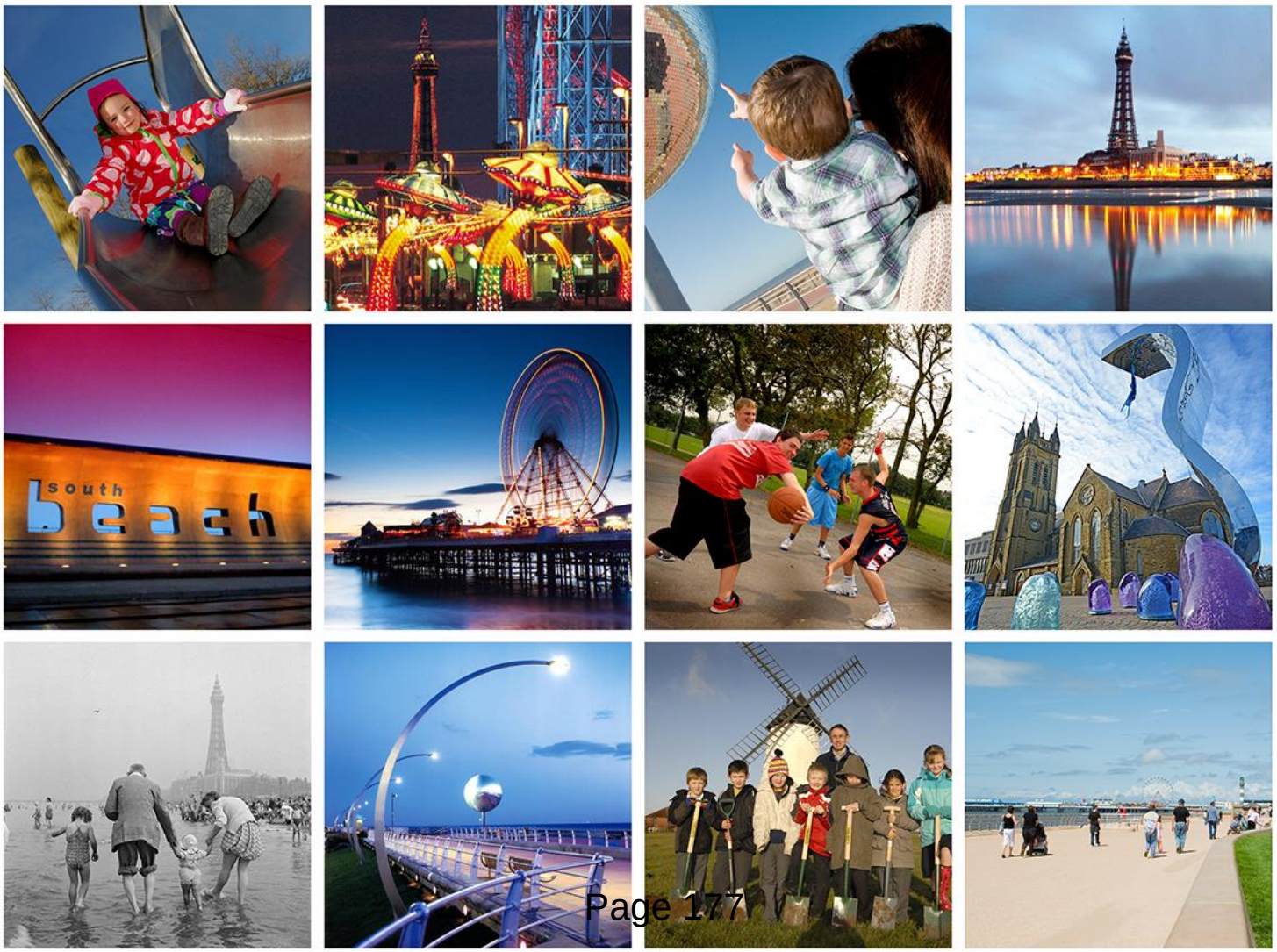
Appendix 6a Health and Wellbeing Strategy 2016 – 2019

Blackpool Council



Health and Wellbeing Strategy for Blackpool

Contents

Foreword	3
Executive Summary	4
Introduction	5
- Health and wellbeing in Blackpool	
- The challenges for children and young people	
- Assets	
The challenges ahead	9
- Healthier Lancashire	
- Fylde Coast Vanguard	
Due North Inquiry	12
Blackpool's Health and Wellbeing Board, vision and priorities	16
1. Housing	17
2. Substance misuse, including alcohol and tobacco	20
3. Creating community resilience and reducing social isolation	24
4. Early intervention	25
Monitoring progress	
Action plan	

Health and Wellbeing Strategy for Blackpool

Foreword

Intro from Cllr Cain

Health and Wellbeing Strategy for Blackpool

Executive Summary

Our vision

Our vision for Blackpool is bold and ambitious:

"Together we will make Blackpool a place where ALL people can live, long, happy and healthy lives"

Our priorities

Evidence related to health outcomes in Blackpool suggests that there are a number of drivers we need to address in order to achieve our vision:

1. **Stabilising the Housing Market**

   Improve the quality, mix, and management of private rented homes through Blackpool Housing Company and other initiatives such as Selective Licensing. Create higher quality new homes at Queen's Park and Foxhall Village.

2. **Substance misuse (alcohol, drugs and tobacco)**

   Address lifestyle issues by supporting policy intervention and education programmes, and deliver the Horizon treatment service to support people with recovery.

3. **Social Isolation/ Community Resilience**

   Address social isolation for all ages and build community resilience.

HOW WILL THIS HAPPEN?

In addition to the above, the board recognises the importance of taking preventative action at the earliest possible time, and addressing the health needs of the youngest, so we have therefore identified an additional priority.

4. **Early Intervention**

   Encourage more upstream intervention at the earliest stage of life and throughout the formative years through programmes such as Better Start and HeadStart; and also by implementing Blackpool's Healthy Weight Strategy.

Picture

Health and Wellbeing Strategy for Blackpool

Introduction

Blackpool is a British institution, and a global phenomenon – the world's first mass market seaside resort, with a proud heritage stretching back over 150 years. More than two thirds of Britons have visited Blackpool, and with 17 million visits per year it is still one of the most popular tourist destinations in the country.

But being the biggest and brightest is not without challenges and Blackpool suffers from complex and intertwined economic, social and health issues which are extremely difficult to remedy.

As Blackpool's Health and Wellbeing Board we are committed to building a thriving, prosperous and beautiful Blackpool with strong and healthy communities, reducing the health inequalities that are clearly evident within Blackpool, and closing the health and wellbeing gap with the rest of the country. It is our duty to bring together local institutions and residents to work together and effect the changes that are desperately needed.

This strategy articulates the Board's vision and priority areas that contribute to the overarching vision for Blackpool:

The UK's number one family resort with a thriving economy that supports a happy and healthy community who are proud of this unique town

And the two priorities which support this:

- **The Economy**: Maximising growth and opportunity across Blackpool; and
- **Communities:** Creating stronger communities and increasing resilience.

Health and Wellbeing in Blackpool

Our Joint Strategic Needs Assessment is constantly being developed to provide detailed evidence which shapes our strategic approach.

Blackpool experiences significant levels of disadvantage; the 2015 IMD ranks Blackpool as the most deprived local authority area in the country based on a number of indicators including health, income, employment, and education and skills. Analysis indicates that the health domain, particularly the level of acute morbidity, is one of the prime drivers behind our decline in the rankings.

It is well documented that Blackpool has some of the most challenging health needs in the country, which places extreme demand on public services.

Life expectancy for men remains the lowest in the country at 74.3 years, and while it is increasing, it is doing so at a slower rate than the rest of the country. For women the picture is only slightly better at 80.1 years although this is also lower than the rest of the country by three years. Even within Blackpool there are large variations in life expectancy, demonstrating the inequalities that exist within the town; this ranges from 71.6 years in the

most deprived ward, Bloomfield, to 80.4 years in Highfield - a difference of over 9 years.

A major driver of poor health in our most deprived wards is poor housing. In the inner areas half of homes are privately rented, with around 89% of rents funded by Housing Benefit. A large proportion of the housing supply in inner Blackpool is characterised by former guest houses that have been converted into houses of multiple occupation (HMO's). This creates a concentration of low-income vulnerable households and results in high levels of transience, and problems of crime, anti-social behaviour, and worklessness.

Blackpool also has lower healthy life expectancy caused by circulatory, digestive and respiratory disease; these are often attributable to lifestyle factors such as smoking and alcohol and substance misuse.

Smoking is the single most important influence on death rates and is a major factor in ill health, including for Blackpool babies – smoking in pregnancy rates are the highest in the country at 28% compared to 12% nationally.

Meanwhile, we also have some of the highest levels of alcohol related harm in the country; this not only directly contributes to health effects such as premature death and chronic liver disease but also carries other consequences such as disorder and violence. There are an estimated 40,000 Blackpool residents who drink at hazardous or harmful levels, equating to 28% of the adult population.

In terms of drug use there are an estimated 1950 opiate and crack users in Blackpool, aged between 15 and 65 years, with an estimated 950 injecting users. The rates of substance misuse are significantly higher than the North West average and more than double the national rate. Two-thirds of users are in the 35 plus age range. Nationally and locally since 2013 the overall rate of people exiting treatment successfully has slowed, this is likely to be a result of those now in treatment having more entrenched drug use and long-standing complex problems.

Addiction is common in people with mental health problems. But although substance abuse and mental health disorders like depression and anxiety are closely linked, one does not directly cause the other. Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse.

As well as poor physical health, Blackpool has the fifth highest rate for all mental health conditions in the country. Mental health problems are among the most common forms of ill health. They can affect people at any point in their lives. Mental health and physical health are inextricably linked. Poor physical health may increase the likelihood of developing poor mental health, and poor mental health may increase risks of developing, or not recovering, from physical health problems.

The association between income poverty and poor mental and/or physical health is well established; the average earnings for those in work in Blackpool is lower than any other local authority in England. Also a smaller proportion of the Blackpool labour market are economically active compared to England, and a high proportion of those inactive are long term sick. In Blackpool, 52% of ESA claimants have a mental health disorder (compared to 46% nationally), and although statistics are not available for JSA customers, JCP surveys suggest a very similar picture.

The challenges for children and young people

For young people growing up in Blackpool, life can be difficult. 28.1% live in low income families, which is the 12th highest in England. All wards in Blackpool have some children living in poverty; however Bloomfield, Claremont, Brunswick and Park wards each have child poverty rates of over 40%.

The lifestyles of parents, in particularly drinking and smoking are shown to have a substantial impact on the development of the foetus and subsequent health of the child. As mentioned earlier 28% of mothers in Blackpool continue to smoke when their babies are born (twice the national level and the highest proportion in England). Around forty four per cent of mothers choose not to try breastfeeding. Among those that do try, only half persist after six to eight weeks.

Unsurprisingly, given these levels of disadvantage, child development outcomes are poor. One in twenty children aged six months to five years has poor speaking or listening skills and results across the Early Years Foundation Stage profile compare poorly against the national average. Following early years, school years and adolescence are areas where other potential health issues are evident.

In terms of children's health the picture in Blackpool is a major concern. Data for 2014/15 shows that 26% of Reception children are overweight and 10% of these are obese, whilst in year 6 the figure increases to 37% overweight with 22% obese; again these figures are higher than the national average. High levels of sugar consumption are widely recognised as a key driver of obesity levels, however it also contributes to poor levels of dental health in children; Blackpool is seeing high numbers of admissions to hospital for tooth extraction under general anaesthetic.

Blackpool has higher than regional and national average teenage pregnancy rates; in 2013, approximately 42 girls aged less than 18 years conceived for every 1,000 females aged 15-17 years. This is a complex issue closely linked to deprivation and low aspirations.

Large numbers of children and young people are exposed to parental problems of mental illness, drug and alcohol abuse and domestic abuse; Women's risk of suffering domestic abuse, for

example, is estimated to be nearly four times the national average.

Whilst the exact number of children affected by parents misusing drugs is unknown. It is reasonably estimated from national data that there are potentially 1500-2500 children affected by parents using opiate and/or crack cocaine; this is expected to be much higher than the national average, and will no doubt have an adverse impact on the child's wellbeing.

The ways in which young people in Blackpool deal with their circumstances can also be the very things we want them to avoid; 15% of older school pupils say they had drunk alcohol in the previous week, and the rate of admissions to hospital amongst our 15-24 year olds for both alcohol and substance misuse is the highest in England and more than double the national average.

There is a growing weight of evidence to suggest a high prevalence of mental health need in our children and as outlined in earlier evidence, Blackpool has a higher presence of some of the key risk factors known to increase the likelihood of children developing a mental health disorder such as substance misuse in pregnancy, poor maternal mental health, poor parenting skills, and child abuse. In addition, Blackpool also has a substantial local population at risk of developing mental health disorders across several of the vulnerable groups; looked after children, young offenders and pupils with special educational needs are especially prevalent. Over half of mental health problems in adult life (excluding dementia) start by the age of 14 and seventy-five per cent by age 18.

Self-harm can occur at any age but is most common in adolescence and young adulthood (10 – 16 years). Females are more likely to self-harm than males, and our rate of self-harm admissions for the same age group is almost triple the national figure, at 917.8 per 100,000. 175 10-16 year olds living in the Blackpool Clinical Commissioning Group area were admitted to hospital because they'd self-harmed or self-poisoned in 2014-15 – just some of the 13% of young people aged 15 or 16 who tell us that they have self-harmed.

All of the factors described above demonstrate the importance of a system-wide approach to prevention and early intervention that acts to promote good health and wellbeing and addresses emerging health issues promptly and in a coherent, joined up way in order to prevent the escalation of poor childhood health outcomes into adolescence and adulthood, and to drastically reduce demand for costly interventions at a later stage.

Assets

Need to add a paragraph here about our assets

The challenges ahead

Given this context, and as public sector organisations face unprecedented budget cuts and the NHS is forced to make considerable efficiency savings it is now more crucial than ever for partners in health, local authority, police, fire and rescue services and the voluntary and community sector to work together to bring about the systems transformation needed to reverse these downward trends and deliver sustainable and long term changes.

We need a major shift in how we deliver health and social care and wider public services, moving away from traditional models of care based on acute services towards more preventative methods which promote self-care and are co-ordinated around the needs of individuals. The Health and Wellbeing Board has a central role to play in co-ordinating and driving this shift at a local level.

While Blackpool has been hit significantly harder by the scale of cuts to services, many other areas also face similar challenges, and this is a driver for reorganisation in many places. As part of central government's devolution agenda, Blackpool is currently in the process of forming a Combined Authority with Lancashire County Council, Blackburn with Darwen Council and the district authorities within Lancashire. Once established, the Combined Authority can negotiate a devolution deal with government which can bring new powers and potentially new resources to the area.

There are five themes of the Combined Authorities' work: economic regeneration, digital and transport connectivity, skills, housing and integrated public services. The latter of these includes health, recognising that population-level health improvement can be achieved in part by re-shaping the healthcare and prevention delivery system.

Healthier Lancashire

Alongside this there is a major programme in place to transform the way that health and social care is delivered across Lancashire through the Healthier Lancashire programme.

The programme was initiated by NHS England in 2013 to respond to the challenges identified in improving poor health outcomes on a Lancashire-wide scale, whilst ensuring that health and care services are sustainable in the long term.

In November 2015 a report commissioned by the Healthier Lancashire organisations outlined the potential resource gap and its drivers, as well as providing six areas of focus where collaboration in considering new service models would potentially help reduce the gap. A commitment to establish a shared programme was given and a Programme Board established to provide leadership and set up governance arrangements.

To ensure that the programme is delivered effectively, governance structures are being reconfigured to reflect the larger geographical footprints of the Local Health and Care Economies (LHCE), which for Blackpool includes neighbouring districts Fylde and Wyre. A pan-Lancashire Health and Wellbeing Board will be established to ensure that all partners are represented in the decision making process.

To mirror the LHCE arrangements, a Fylde Coast Health and Wellbeing Partnership is being considered. This board will be a key link between CCG's and local authorities and other public sector organisations and will be central to the decision making process for Healthier Lancashire. (Some content is subject to change depending on future developments)

National NHS Planning Guidance published in December 2015 set out plans to deliver the Five Year Forward View through the development of NHS Sustainability and Transformation Plans to be submitted by July 2016. These are collaborations between health commissioners, providers and local authorities and are central to accessing transformation funding for local areas to deliver efficiencies in the system. The focus of the plans is on three areas:

- Closing the health and wellbeing gap
- Driving transformation to close the care and quality gap and;
- Closing the finance and efficiency gap

More info needed re what the STP will do

Fylde Coast Vanguard – new models of care

A central element to the transformation of health and care services across the Fylde Coast is the Vanguard new models of care programme. The programme cuts across the Board's priorities and will change the way health services are delivered.

The new care models, Extensivist and Enhanced Primary Care are designed to ensure that health and social care services for the people of the Fylde Coast are integrated to provide better care outside of hospital, and that parity of esteem is achieved between physical and mental health needs. The models bring health, social and third sector services together based within neighbourhoods with a focus on prevention, early intervention, shared decision making and self-care.

Extensive care is focused initially on patients over 60 years of age with two or more long term conditions, enhanced primary care is focused on patients with one or more long term conditions; The models provide pro-active and co-ordinated care wrapped around the patient, and are fundamentally oriented toward supporting patients so they have the confidence and knowledge to manage their own conditions.

One of the key components is clear patient accountability; decisions are made by the patient with the support of the lead professional and their care team, which includes the new role 'health and wellbeing support worker'. The care team has holistic responsibility for the

patient's care, acting as a co-ordinating point across the local health and care system.

It is anticipated that these models will significantly improve the patient experience, with patients being empowered to manage their own health and having an increased sense of wellbeing as a result. There will be fewer unnecessary outpatient consultants and investigations, fewer planned and unplanned hospital admissions and better use of technology.

Ultimately, the Fylde Coast Vanguard is aspiring to devolve local resources to local providers where possible, ensuring that services are truly integrated, and health and social care outcomes for the Fylde Coast population are further improved.

Due North Inquiry

In 2015, the Due North Report of the Inquiry on Health Equity in the North was published. The report was commissioned by Public Health England to examine health inequalities in the North of England.

The report identifies that there is a clear 'North-South divide' in England when it comes to health. Since 1965, there have been 1.5 million excess premature deaths in the North compared to the rest of the country due to poorer health. A baby boy born in Blackpool today will live eight fewer years than a child born today in Kensington and Chelsea. These health inequalities are not fair, just or inevitable and can be avoided through appropriate action.

Due North makes a number of recommendations for local areas to take forward; many of these broadly align with the board's priorities and have informed the thinking behind this strategy. We have developed an action plan, which maps our activity and progress against the Due North recommendations in more depth; this can be found at appendix xx.

The recommendations are summarised below:

1. Tackle poverty and inequality

Tackling poverty and inequality is a theme running across all of our health and wellbeing priorities. Due North suggests that one of the consequences of the uneven economic development in the UK has been higher unemployment, lower incomes, adverse working conditions, poorer housing, and higher debts in the North, all of which adversely impact health and increase health inequalities.

The adverse impact of unemployment on health is well established. Studies have consistently shown that unemployment increases the chances of poor health. The negative health experiences of unemployment also extend to families and the wider community.

High levels of chronic illness in the North, and particularly in Blackpool, contribute to lower levels of employment, 12.8 per cent of Blackpool's working age population claim ESA or Incapacity Benefit; this is more than double the national average.

The report highlights the inverse relationship between income and health, and how increases in poverty are associated with a greater risk of physical and mental health problems. The burden of local authority cuts and welfare reforms has fallen more heavily on the North than the South. Research by Sheffield Hallam University on the impact of all of the recent welfare reforms has shown that Blackpool has been the hardest hit of all the local authorities, with a loss of £914 for every working age adult.

The Blackpool, Fylde and Wyre Economic Development Company's 'Framework for Inclusive Growth and Prosperity' describes its key objective 'to deliver **inclusive economic growth and prosperity,** and in doing this, close

our performance gap with national averages and **drive improvement in the quality of life and health of our people and businesses, now and into the future.'**

To achieve this objective we need to support and enable people who have health problems to return to work and maintain employment, we are beginning to develop initiatives in this area and are one of four areas piloting a new programme of integrated employment coaching and health therapies to improve the work and health outcomes of jobseekers assessed as having common mental health disorders.

This work is based on evidence in relation to health trainers/ health coaching and social prescribing models to improve the health and wellbeing of the population and reduce reliance on health care services. The HealthWorks hub will be easily accessible and will offer drop-in self-referral activities for health and employment information, self-care advice, support and access to services as well as referrals from professionals and partner agencies.

The hub has been jointly commissioned by the Council, DWP and Blackpool CCG to provide a lifestyle management service across Blackpool and will also closely link to the Vanguard programme described earlier.

2. Promote healthy development in early childhood

There is a large amount of evidence that children who experience disadvantage during their early years are more likely to have poorer health and development outcomes in later life. The Marmot review of health inequalities states that "Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken".

The previous section describes some of the current challenges faced by children and young people living in Blackpool. Our systems transformation programme 'A Better Start' is aimed at giving every child the best start in life working with families in pregnancy and with children up to three in Blackpool's most deprived wards. A Better Start means to break the intergenerational cycles of poor outcomes in our children and families. It uses the latest research and evidence to ensure families experience a healthy gestation and birth and children are ready for school. The three key outcome areas are improving Language and Communication, Social and Emotional Development and Diet and Nutrition.

Interventions focus on reducing the key risk factors affecting parenting, for example drugs and alcohol, mental ill-health, relationship

conflict and domestic abuse, and social isolation; and empowering parents and communities to make positive changes, promoting good parenting, healthy parent-child relationships, self-efficacy and social cohesion.

Since September 2015, parents in the seven Better Start wards have had an evidence based universal, antenatal offer which includes targeted support through Family Nurse Partnership to support new mothers under 20 years and Baby Steps for all parents over 20 years. To date 308 parents to be have been offered Baby Steps through the midwives at their first appointment. The Baby Steps team is made up of health visitors, family engagement workers, midwives and star buddies working in partnership through the Children's Centres.

3. Sharing power over resources

Due North advocates greater devolution of power and resources so that the North can develop tailor-made solutions to its problems, whilst at the same time making efforts to increase public participation in deciding how resources are used and decisions made.

The report also identifies three ways in which the lack of influence and democratic engagement impacts on health and health inequalities:

1. The very act of getting together; getting involved and influencing decisions builds social capital leading to health benefits
2. Stress is reduced if people can influence and feel in control of their living environment
3. Those who have less influence are less able to affect the use of public resources to improve their health and wellbeing.

In Blackpool, as elsewhere, there are lower levels of political engagement in the more deprived areas. At the last election for example, in Bloomfield ward voter turnout was 26.5% compared to 48% of registered voters in Norbreck.

To increase levels of participation and engagement Blackpool has an ambition to create a culture of asset based community development (ABCD), which will permeate throughout Blackpool engaging both organisations and communities in creating a social movement of healthier, more connected and more resilient communities.

4. Role of the health sector in promoting health equity

Whilst life expectancy has increased in recent years and mortality reduced, it is estimated that less than a quarter of this is due to health care and the rest is due to improvements in other social determinants and preventative measures; the North still experiences higher rates of mortality amenable to health care than the rest of England.

The Due North report also found that, following the move of Public Health to Local Authorities, the NHS and the new Clinical Commissioning Groups are focusing more on reducing the demand on services by managing frequent users of services rather than the social factors that cause the high demand in the first place. An approach that is not sustainable.

The health sector can still play an important role in reducing health inequalities by:

1. providing equitable, high-quality health care;

2. directly influencing the social determinants of health through procurement, and as an employer; and

3. being a champion and facilitator who influences other sectors.

Blackpool's Health and Wellbeing Board

Health and Wellbeing Boards are an important feature of the Health and Social Care Act 2012. Blackpool's Health and Wellbeing Board was established in 'shadow form' in December 2011 and became a formal statutory committee of the council in May 2013.

The Board's membership builds on strong pre-existing partnerships between the NHS, Council and other public, voluntary sector and statutory partners (a full list of members is included at appendix B).

Its responsibilities include oversight of the implementation of a number of important national and local policy agendas for example; the Care Act, the NHS Five Year Forward View, the Children and Families Act, and Future in Mind.

Our vision

Our vision for Blackpool is bold and ambitious:

"Together we will make Blackpool a place where ALL people can live, long, happy and healthy lives"

Our priorities

Evidence suggests that from a health perspective, addressing the following drivers is key to achieving the vision:

1. **Stabilising the Housing Market** – Reduce the availability of Houses of Multiple Occupation (HMO's) via the Blackpool Housing Company and other initiatives such as Selective Licensing to improve standards in the private rented sector. Create higher quality housing and mix of tenure by redeveloping Queen's Park and developing new housing at Foxhall Village.
2. **Substance misuse (alcohol, drugs and tobacco)** – Address lifestyle issues by supporting education programmes and policy intervention.
3. **Social Isolation/ Community Resilience** – Address social isolation for all ages and build community resilience.

In addition to the above, the board recognises the importance of taking preventative action at the earliest possible time, and addressing the health needs of the youngest, so we have therefore identified an additional priority.

4. **Early Intervention** – Encourage more upstream intervention at the earliest stage of life and throughout the formative years through programmes such as Better Start and HeadStart; and also by implementing Blackpool's Healthy Weight Strategy.

1. Housing

The link between poor health and poor housing has long been established; research shows that inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer. Poor housing also negatively impacts on an individual's physical and mental wellbeing and on children's ability to perform well at school, and is estimated to cost the NHS at least £600 million per year.

Blackpool experiences among the lowest rates of life expectancy in the country and this is largely concentrated in the inner areas where private rented housing is most prevalent – 50% of all households in the inner area live in a privately rented home, equivalent to 6,887 households.

Many of these are former traditional guest houses that have been converted in poor quality privately rented flats or houses in multiple occupation. Poor quality housing is generally only accessed by households who are unable to access better housing choices, and there is continuing demand from people attracted to the town from deprived urban areas in other parts of the UK. This means that many people moving into the area have no real association with the community and are likely to quickly move on again.

Over 80% of homes in the private rented sector are rented to people receiving Housing Benefit, compared with around 30% nationally.

Analysis of new Housing Benefit claimants has shown that 85% of new claimants come from outside the borough – around 4,500 households each year – and that 70% of these move into rented accommodation in the inner wards.

This transient dynamic leads to intense concentrations of deprivation and an environment that fosters poor health and a lack of opportunity for residents. Low life expectancy and mental health problems in these areas are amongst the worst in the country. The poor environment and endemic social problems in the inner town also have a serious negative effect on tourism.

There are financial incentives for property owners to use former guesthouses as rented accommodation, because of the high yields associated with letting rented property to Housing Benefit claimants in Blackpool. The returns are greatest for small flats and where investment in the quality of accommodation is minimized.

Not only does this economic model deliver unstable communities constantly seeing a change of population, it also exerts a massive strain on public services as new residents drawn to the ready supply of accessible accommodation bring with them a range of embedded and enduring problems that get referred to public services already under strain.

Intervening in the housing market to change the current dynamic is essential if the efforts of public services to improve the life chances of residents and to transform our deprived inner areas into thriving neighbourhoods are to be successful. There are a number of important areas where we need to focus our efforts:

Firstly, it is essential that we tackle the failing housing market in parts of the town by promoting change in the housing stock and inner neighbourhoods, and reducing transience and concentrations of severe deprivation over the long term.

The Blackpool Housing Company has been established to begin the transformation of the private rented sector. The Company acquires properties that need improvement, converts and refurbishes them to a high standard and lets them at market rents to local tenants. It is anticipated that the Company will own one thousand units in the next five years.

The Council is currently redeveloping the Queen's Park estate, demolishing the 500 high-rise flats to build 191 new houses and low-rise flats to create more desirable communities.

In addition a large new build development is currently being constructed in the Bloomfield area. The site includes 410 new homes, which are innovative and attractive, of which 70 are available for affordable rent.

Secondly, we must improve conditions within the housing stock to keep people safe and warm and enable people to access the kinds of housing that people need, including effective commissioning of specialist supported housing. This is essential in reducing some of the chronic physical and mental health conditions associated with poor housing.

To improve standards within the private rented sector we have introduced selective licensing schemes in the Claremont and South Beach areas and are about to roll out a new scheme to the central area of Blackpool. The schemes have improved the management of standards and have reduced anti-social behaviour by tenants.

We are also leading part in Cosy Homes in Lancashire; this is a county-wide home energy efficiency and affordable warmth pilot initiative aimed at using grants from energy companies (particularly the Energy Company Obligation or 'ECO') and other sources to fund new heating measures, insulation and renewable technologies in domestic properties. The outcome will be a reduction in energy bills and an increase in the 'thermal comfort' of homes, leading to a reduction in cold-related illnesses and associated GP and hospital visits.

Thirdly, we must support vulnerable people with their housing needs, for example;

1. Those at the point of hospital discharge so that they can return to and remain at home, preventing unnecessary admission to hospital.

2. People with chaotic lifestyles or multiple and complex needs including substance and/or alcohol misuse, mental ill health or homelessness.

3. Young people, including those leaving care, who often require support making the transition to independent living.

A great deal of work is ongoing to support vulnerable people but there is potential to further improve this by joining up health and social care services better. We want to improve outcomes for the individual and alleviate pressure on the NHS.

We are currently developing an Older Person's Housing and Support Strategy that will identify the housing needs of older people and set out a plan for the future provision. One of the aims will be to improve people's homes by reviewing the aids and adaptation programme and how funds are allocated, this will help to reduce delays for those who are awaiting hospital discharge.

The strategy will also review the future for sheltered housing and understand what changes are required to meet future demands; and understand the demand for and impact of Extra Care Schemes and to investigate the feasibility of commissioning new developments should excess demand be identified.

As described in earlier sections, Blackpool has high numbers of people with chaotic lifestyles and complex and multiple needs.

A transience programme has operated in the South Beach and Claremont areas to identify people with support needs and signpost them to relevant services. An important element to this has been community development and building social networks to improve confidence and mutual support.

As the Vanguard Programme is rolled out across Blackpool and into the inner areas, the transience programme will help identify residents who need support and are not accessing services, and ensure that they are included.

The Council's Housing Options team will continue to work to prevent and resolve homelessness, providing advice and assistance to up to 2,500 households each year. This is backed up by supported housing providers, voluntary agencies, and tenancy support and training provision. Maintaining people in stable home environments is critical to improving health and wellbeing.

New, holistic, support for young people will be delivered through a new Vulnerable Adolescents' Hub, alongside more work to prevent homelessness caused by family breakdown, and a wider range of housing and support options for all vulnerable young people.

2. Substance misuse, including alcohol and tobacco

Substance misuse including alcohol and tobacco brings a wide range of problems and is a major public health issue. The health and social problems they cause are significant, wide ranging and costly.

Alcohol

Alcohol, and people's relationship with it, is particularly problematic in Blackpool; it is one of the main causes of shorter life expectancy, causing and contributing to numerous physical and mental health problems including kidney and liver disease, cancer, heart disease, stroke and depression as well as foetal alcohol spectrum disorder and related developmental conditions in children of women who have consumed alcohol whilst pregnant.

Blackpool's historic drinking culture associated with hen and stag parties has had a lasting impact on perceptions of alcohol use as socially acceptable pastime; combined with other socio-economic problems this results in a significantly higher than average alcohol related mortality rates and the highest rate of alcohol related admissions to hospital in England.

Our refreshed Alcohol Strategy 2016 – 19 focuses on reducing the harm caused by alcohol, based around three priority areas.

1. **Developing healthy attitudes to alcohol across the life course** – this includes preconception with women to reduce alcohol exposed pregnancies, and alcohol consumption and the effects on families with early years children; delivered through Better Start and described in more detail in later sections. For school age children, interventions include PHSE programmes in secondary schools and for adults, campaigns to raise awareness of the risks associated with excessive drinking.

2. **Changing the environment and promoting responsible retailing** – we will continue to use enforcement and planning regulations to ensure that harm from alcohol is minimised by not granting licenses to establishments where there is already an oversupply of alcohol, and by carrying out test-purchasing to ensure that regulations regarding the sale of alcohol are being followed. We will continue to lobby for a national Minimum Unit Price for alcohol, and for a public health licensing objective.

3. **Early identification and support for alcohol issues** – we will commission services to ensure that adults and children with alcohol misuse problems can access effective treatment services and recovery support. We will have a focus on early intervention so will train wide ranging staff to identify people drinking at harmful levels and direct them to appropriate support.

Drugs

While all drugs have damaging impacts, the most harmful drugs, including heroin and crack cocaine bring untold misery to individuals, their families and communities. Problem drug use is an issue which has an impact on society as a whole, but disproportionately affects the most deprived communities, disadvantaged families and vulnerable individuals.

Previously, policy has tended to concentrate on treatment and harm reduction and not the wider implications. The new Drug Strategy for Blackpool takes a whole system approach to the issues caused by drug misuse. The key objectives, which have been endorsed by the board, are to:

- Prevent harm to individuals
- Build recovery
- Prevent harm to the community
- Empower young people to make informed choices
- Keep children safe and rebuild families
- Build community and increase engagement and inclusiveness in Blackpool

Key actions need to be included for alcohol and substance misuse – what about dual diagnosis and links to mental health

Fulfilling Lives

In 2014, Blackpool was chosen by the Big Lottery to receive funding to deliver the Fulfilling Lives: Complex Needs programme; Blackpool received £10 million to deliver the project, which is about building recovery.

The aim is to improve the stability, confidence and capability of people with multiple and complex needs including: homelessness, reoffending, problematic substance misuse and mental ill health resulting in a positive impact on local communities across Blackpool. It also aims to change systems to better deal with these people in the future and to significantly reduce the current costs incurred by emergency services such as the police and ambulance service in responding to people living chaotic lifestyles.

Considerable emphasis has been placed on the involvement of ex-service users (people who previously had chaotic lifestyles caused by problems with alcohol, drugs, offending behaviour, homelessness and mental health issues) in the design and delivery of this programme. They use their skills, knowledge and experience to identify, engage with and support people currently living chaotic lives.

Outcomes so far? (See evaluation when available)

New Psychoactive Substances

In recent years, the United Kingdom has seen the emergence of New Psychoactive Substances (NPS) that have similar effects to drugs that are internationally controlled. They have increasingly become more popular since 2008/9 and present a relative new challenge in drugs

policy and being developed at such a speed never seen before in the drugs market. These drugs have been designed to evade drug laws, are widely available and have the potential to pose serious risks to public health and safety and can even be fatal.

The Health and Wellbeing Board debated the issues NPS present for Blackpool and noted the work undertaken by the Council's Public Protection team to close all Head Shops in Blackpool.

In January 2016 the Psychoactive Substance Act 2016 was passed and is due to be implemented later in the year.

Tobacco

Effective tobacco control is central to realising the right to life and the right to the highest attainable standard of health for everyone in Blackpool. It recognises that people deserve to live in a town free from the harms caused by tobacco, where people choose not to smoke and enjoy longer, healthier lives.

Whilst figures in other areas of England have seen reductions in the numbers of adults who smoke, in Blackpool the figures have remained static over the last few years at around 27.2% of the adult population smoking as compared to the England average at 20%. For Blackpool to become a more successful town, with opportunities for everyone to flourish, we need to remove the burden of ill health, which tobacco contributes significantly to.

The Blackpool Tobacco Strategy therefore sets out a range of actions across three priority themes, as we believe these to be the areas of greatest opportunity where the greatest differences can be made:

- **Prevention** – creating an environment where (young) people choose not to smoke
- **Protection** – protecting people from second hand smoke
- **Cessation** – helping people to quit smoking

This will be achieved by:

1. Reducing health inequalities through reduced tobacco consumption; helping tobacco users to quit and reducing exposure to second hand smoke.
2. Reducing the promotion of tobacco, communicating for tobacco control and effectively regulating tobacco/nicotine containing products.
3. Making tobacco less accessible by considering licensing sales/local initiatives and reduce the flow of illicit and illegal tobacco products into Blackpool.
4. Ensuring that tobacco control is prioritised in cross-cutting policies, education, guidance and funding and

protecting tobacco control policy from industry influence.

5. Working with communities to change the cultural norms around smoking.

3. Creating community resilience and reducing social isolation

As public sector resources diminish and we no longer have the funding to provide services to support people's health and social care needs in the same way as previously, we have to find ways to support people in different ways, encouraging them to become more resilient and less reliant on our services.

There are a number of projects being delivered by different organisations in different neighbourhoods that are focused on developing communities, reducing isolation and increasing resilience.

Volunteering is integral to this and as our own resources and capacity diminishes, we are becoming increasingly reliant on the voluntary sector for support in delivering key aspects of our work to build resilient communities.

Volunteer strategy

As part of Better Start, work has been ongoing to develop Community Champions who will ensure that all parents are given the support they require within pregnancy and the early years to become more active within their communities to make positive sustainable changes. Better Start will through innovative community action projects develop services and resources for parents by parents.

As part of the new models of care vanguard we will be introducing neighbourhood navigators…

Community Oriented Primary Care?

Police – (volunteers)

This needs the discussion on what our strategic approach to the third sector is…

4. Early intervention

In previous sections we have described the priority areas that need to be addressed, and where intervention is most needed if we are to improve health and wellbeing for our communities. This priority is about how we will need to take a different approach to the way public sector organisations operate and deliver services in the future; this is an absolute necessity if we are to remain sustainable and able to continue helping those people in greatest need. We simply cannot afford to continue responding to individual problems in a disjointed and ad hoc manner, once issues have reached crisis point.

In Blackpool we have a unique opportunity to turn things around. There has been considerable investment in Blackpool in recent years as various partnerships have been successful in securing funding through the Big Lottery Fund. This additional investment will facilitate the systems transformation required to improve outcomes in the long term and change the way that services are delivered, not just enable a short term continuation.

The most significant of these is the funding for 'A Better Start', in partnership with the NSPCC; in July 2014 we secured £45 million over a ten year period to improve outcomes for all pre-birth to age three children and families across Blackpool.

Blackpool Better Start's aim is to deliver lasting change so that Blackpool will be a place in which families raise happy, healthy children who grow up to take pride in belonging to, and giving back to, the community. Better Start has two key development outcomes: **healthy gestation and birth** and **readiness for school;** these are recognised as key development milestones for children.

It will improve services for 0-3 year olds and their families. The Blackpool Better Start programme is underpinned by four cornerstones:

- Grounded in a Public Health approach
- Using Evidence Based programmes
- Systems transformation and reframing of Early Child Development
- Centre for Early child Development

Initial work focuses on the seven wards where the local communities face the greatest challenges: Bloomfield, Brunswick, Claremont, Clifton, Park, Talbot and Victoria.

HeadStart is one of the newer systems change initiatives currently underway in Blackpool; the funding secured in earlier bidding rounds has informed the development of the recently submitted stage 3 bid, which has also benefited from work on Better Start, Multiple Complex Needs and Vanguard initiatives – all of which put individual needs at the heart of their processes.

HeadStart aims to build resilience in young people aged ten to sixteen years to help them cope with life's challenges and prevent mental health problems from developing in later life. The programme will develop resilient environments in schools and communities by embracing the approach of proportionate universalism advocated in the Marmot Review.

We want to increase all young people's resilience to enable them to cope with life's challenges. The larger universal population will need a lesser level of support to achieve this and the smaller proportion of Universal + and Universal ++ will need a greater level of support, this proportionate level of support achieves ideal levels of resilience for the population of 10-16 year olds in Blackpool.

The clearest link to HeadStart is Better Start, as mentioned above. Together, these investments put us in the unique position of being able to develop a town wide prevention strategy for our children and young people - a "cradle to college" approach. This is supported by the integration of both Big Lottery Funded initiatives into our newly-developed Emotional Health and Wellbeing Transformation Plan, which will deliver a new approach to ensuring emotional health and wellbeing of children and young people of all ages in Blackpool.

Healthy Weight

At the beginning of this strategy we described some of the challenges that our children and young people are facing, with health and particularly healthy weight being a major concern. This is an area where we must intervene at the earliest possible stage to reverse some of the worrying trends that are starting to take hold.

There is a growing consensus that preventing childhood obesity is key to achieving healthy lives in adulthood and ultimately to reversing obesity prevalence. The Healthy Weight Strategy 2014 – 16 proposes a whole system approach to the problem of obesity, suggesting that to achieve this we need to change our approach as a society to food, drinks and physical activity and prioritise the creation of 'healthy-preference learning environments' for children.

The strategy's main priorities for continuing to address and reduce levels of overweight and obesity in children and adults include:

- Increase knowledge, skills and abilities about healthy eating
- Make healthy choices the default choice
- Pricing
- Availability of unhealthy foods
- Redesigning environments to promote physical activity and healthy food
- Reducing sugar consumption

Section about Early Action

Monitoring progress

Regular progress reports to board/debates…

What are key performance indicators from each org?

How does Board want to monitor performance of priorities?

Health and Wellbeing Strategy for Blackpool

Appendix A

Health and Wellbeing Strategy for Blackpool

Document Control

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Date	Version	Amended by	Description of changes
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17 March 2016	2	Venessa Beckett	Comments and suggestions on data (John Patterson)
21 March 2016	3	Venessa Beckett	Comments and suggestions on content and structure (Scott Butterfield)
30 March 2016	4	Venessa Beckett	Amended Housing section (Andrew Foot)
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1 April 2016	7	Venessa Beckett	Inserted sections on Better Start (Annette Algie)
1 April 2016	8	Venessa Beckett	Inserted section on NPS and Fulfilling Lives (Nicky Dennison)

Approved By:

Name	Title	Signature	Date

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary- Resilient Communities
Date of Meeting:	20 April 2016

HEALTHIER LANCASHIRE UPDATE

1.0 Purpose of the report:

1.1 To ensure that the organisations on the Health and Wellbeing Board are aware of the establishment of the Joint Committee of Clinical Commissioning Groups (JCCCG) and their role in it or in relation to it.

Briefly to confirm with the Board the arrangements for developing a Sustainability and Transformation Plan on a Lancashire and South Cumbria footprint, to assure the Board that this is aligned to the development of Healthier Lancashire.

2.0 Recommendation(s):

2.1 To note the update on the Healthier Lancashire including the establishment of the Joint Committee of Clinical Commissioning Groups.

2.2 To agree that the Board continues to receive regular updates from the Healthier Lancashire Programme in respect of the establishment of the appropriate governance arrangements and resourcing of the programme structure.

3.0 Reasons for recommendation(s):

3.1 The Board will have a role in supporting the proposals coming out from the Healthier Lancashire Programme and ensuring the appropriate challenge and scrutiny has been undertaken in relation to those proposals.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is: "Communities: Creating stronger communities and increasing resilience."

5.0 Background Information

5.1 On 19 November 2015, the Healthier Lancashire Executive Summit agreed to undertake activities to complete the Strategic Planning Phase to establish the Healthier Lancashire Programme. As part of this commitment the cadre of executive leaders from the Lancashire Health and Care System then participated in a governance workshop on 30 November 2015. This workshop was facilitated by Capsticks LLP and led by Gerard Hanratty, a partner at the firm, who has extensive experience in supporting reconfiguration work across health and social care through a number of programmes across the UK.

The outcome of the workshop was a further draft of the governance and decision making arrangements and the supporting programme structure and the confirmation that a Joint Committee of Clinical Commissioning Groups was the right legal entity to ensure collaborative decision making and leadership of the Healthier Lancashire programme of work.

Mr Hanratty produced a report following the workshop and this was circulated to all participating organisations in November 2015.

5.2 December 2015 to February 2016 – Joint Committee of Clinical Commissioning Groups Terms of Reference

During December 2015 organisations participating in designing and establishing the Healthier Lancashire Programme had reviewed the Capsticks Report and comments and views were considered, particularly in relation to what would be delegated to the Joint Committee of Clinical Commissioning Groups and who would be included to meet in collaboration with the Clinical Commissioning Group, but would not be

voting members of the Joint Committee.

Dr Amanda Doyle, Senior Responsible Officer for Healthier Lancashire and the Sustainability and Transformation Plan Lead for the Lancashire and South Cumbria Footprint had a number of discussions with Clinical Commissioning Group Accountable Officers, Chief Operating Officers and others in relation to establishing the Joint Committee.

As a result the draft Joint Committee of Clinical Commissioning Group Terms of Reference was amended and a number of questions responded to in a final draft version, an Appendix containing the scheme of delegation and a note setting out the definitions.

5.3 March 2016 – Establishing the Joint Committee of Clinical Commissioning Groups

In February and March the organisations participating in Healthier Lancashire were provided with the final draft of the governance and programme structure arrangements. This was in the form of a large slide deck and covering paper. This set the Joint Committee of Clinical Commissioning Groups in the context of Healthier Lancashire and it is with this in mind that Clinical Commissioning Groups governing bodies have been asked to consider the Joint Committee of Clinical Commissioning Groups Terms of Reference and Appendix at their meetings in March. They should consider the scheme of delegation which is set out in three categories:

- The Healthier Lancashire Programme
- Existing collaborative programmes of work (currently under the remit of the Collaborative Commissioning Board)
- Any future ad hoc collaborative programmes of work not covered by the Healthier Lancashire Programme

The Note on creating the Joint Committee of Clinical Commissioning Groups provided by Capsticks asks governing bodies and boards to provide a 'Minute of Decision' recording their agreement to the establishment of the Joint Committee of Clinical Commissioning Groups and the delegation of the functions and duties set out in the Delegation.

In addition each Clinical Commissioning Group is asked to state who is their appointed voting representatives on the Joint Committee of Clinical Commissioning Groups

Following receipt of the decision from each of the Clinical Commissioning Groups the Joint Committee of Clinical Commissioning Groups schedule of meetings will be established. If there are no issues the plan is to hold the first Joint Committee of Clinical Commissioning Groups meeting in May 2016

5.4 The Sustainability and Transformation Plan

On 22 December 2015 NHS England published the Delivering the Forward View: NHS planning guidance. This set out a list of national priorities for 2016/17 and longer term challenges for local systems, together with financial assumptions and business rules. For the first time the Mandate is not solely for the NHS commissioning system, but the NHS as a whole. NHS England required two separate, but connected plans:

- A five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- A one year Operational Plan for 2016/17, organisation based, but consistent with the emerging Sustainability and Transformation Plan.

NHS England states that the scale of what Healthier Lancashire needs to do in the future depends on how well Healthier Lancashire and partners end the current year. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign.

The guidance asks every health and care system to come together, to create its own ambitious blueprint for accelerating its implementation of the 5 Year Forward View. Sustainability and Transformation Plans will cover the period between October 2016 and March 2021. It is an umbrella plan holding underneath it a number of specific delivery plans, some of which will necessarily be on different geographical footprints.

The Sustainability and Transformation Plans are about the holistic pursuit of the triple aims – better health, transformed quality of care delivery and sustainable finances. Health and Care Systems are asked to first focus on creating an overall vision and the three overarching aims – rather than attempting to answer all of the specifics at the start.

As Healthier Lancashire, the Health and Care System had already committed to developing a strategic plan supported by local delivery plans. This is still the intention and the planning guidance reinforces this imperative as well as introducing a sense of urgency and pace to the work we were already committed to doing.

5.5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

Appendix 7a: Healthier Lancashire Completing the Strategic Planning Phase

6.0 Legal considerations:

6.1 The establishment of the Joint Committee of Clinical Commissioning Groups will need to follow legislation and the Programme will adhere to all appropriate legislation and guidelines.

7.0 Human Resources considerations:

7.1 At this stage there are no human resource issues, but the need to release staff to participate in and provide the relevant expertise to a dispersed leadership model will need to be considered in the future. This will be part of completing the Strategic Planning Phase and establishing the programme over the next three months.

8.0 Equalities considerations:

8.1 The Healthier Lancashire Programme will include at every stage of solution design and implementation the requirement for Equality Impact Assessment and has included this in its governance and programme arrangements at this very early stage.

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None, the report is for information only.

11.0 Ethical considerations:

11.1 The Healthier Lancashire Programme is working to develop its principles and values and would look to ensure that these support the values, morals and beliefs of the organisations involved.

12.0 Internal/ External Consultation undertaken:

12.1 Not applicable.

13.0 Background papers:

13.1 Healthier Lancashire Governance Slide Deck.

Appendix 7a Healthier Lancashire Completing the Strategic Planning Phase

Name of Paper	Healthier Lancashire Completing the Strategic Planning Phase
Lead Author	Samantha Nicol, Healthier Lancashire Director
Contributors	Ian Tomlinson, Gary Raphael, Emma Harrison
Purpose of Paper	The purpose of this paper and the appended slide deck is to support the Healthier Lancashire Executive Leadership to discuss with their governing bodies and boards the Healthier Lancashire governance, programme and resourcing arrangements. These arrangements are expected to be the mechanism through which the Sustainability and Transformation Plan for Lancashire and South Cumbria will be developed.
Exec Summary	The paper builds on the agreement to complete the activities within the Strategic Planning Phase, made at the Executive Leadership Summit and Governance Workshop both held at the end of November 2015. This ensures that Healthier Lancashire is built on firm foundations; as historically such programmes have found progress challenging and decisions challenged when governance arrangements have not been robust. The focus is on the proposed governance and programme arrangements for Healthier Lancashire and organisations are asked confirm their agreement to these. The gaps in the dispersed leadership model are highlighted and processes set out to fill them. The recommendation in relation to the resource plan and funding model will be finalised through the Lancashire Finance Network.
Recommendations	Lancashire Leadership Forum, Collaborative Commissioning Board members and Lancashire Transformation Executive Group members are asked to:

	• Note the contents of this report and include it as an item for discussion across their Board/Governing Body/Senior Management Team meetings during March 2016. • Ensure that this paper and appended slide deck are included as an agenda item at their March 2016 Board; Governing Body or Senior Management Team meetings. The paper is for discussion in the private part of these meetings. • Seek the agreement to the governance and programme arrangements for Healthier Lancashire and confirm their commitment to working within these. • Note the proposals for filling the gaps in the dispersed leadership model and support colleagues, from within their organisations, to come forward and express their interest in the roles. • Use this as background to support the decision on the resource plan and funding model to be presented by the finance leads separately for agreement • Assure their governing bodies and boards that a final paper for public meetings will be provided for meetings in April.
Next steps	The next steps are set out based on the identified dependencies and aligned to the Healthier Lancashire plan's critical path. • Enact the processes to fill the vacant leadership roles • Establish the Joint Committee • Complete the establishment of the work streams • Align Healthier Lancashire and Local Health and Care Economy governance and programme arrangements • Establish the Programme Board • Agree the Resource Plan and Funding Model

1. Introduction

1.1. At the Executive Leadership Summit on 19th November 2015 the leaders of health and local government organisations, from across Lancashire, came together and made a commitment to complete the Strategic Planning Phase of Healthier Lancashire. This collaborative commitment was based on the understanding that there was a need for a shared programme of work across Lancashire to develop a plan for sustainable health and care public services, at a scale and pace that had been directed by the recommendations made in the Alignment of the Plans Report, published in October 2015.

1.2. At the Summit there was also commitment to:

1.2.1. Use local senior leaders to chair the committees and groups in the governance structure with external expert reference group/advisory arrangements and build on work/groups already in place to strengthen leadership (Carnall Farrar Executive Leadership Summit Report November 2015)

1.2.2. This has been a core principle of the development of the governance and programme arrangements.

1.3. The Governance Workshop on 30th November 2016 recognised that transformational change programmes, of the size of Healthier Lancashire, have historically found progress challenging and decisions challenged when governance arrangements are not robust. The emphasis on building firm foundations and recognising that work and decisions need to be taken at a number of levels and dependent on the issue is also another key principle on which these proposals have been developed.

1.4. This paper focuses on the governance and programme arrangements of Healthier Lancashire and the resource plan to support them. It sets out the proposed governance structure, and the supporting programme structure. The paper details the dispersed leadership model and the process to secure the required resources to mobilise these arrangements.

1.5. This paper does not set out detail on the other activities included in the Strategic Planning Phase.

1.6. While this paper does not set out the process for developing a Sustainability and Transformation Plan (STP) for Lancashire and South Cumbria, the governance and programme arrangements will be the mechanism through which the STP is produced.

2. Governance and Programme Structure and Resource Plan

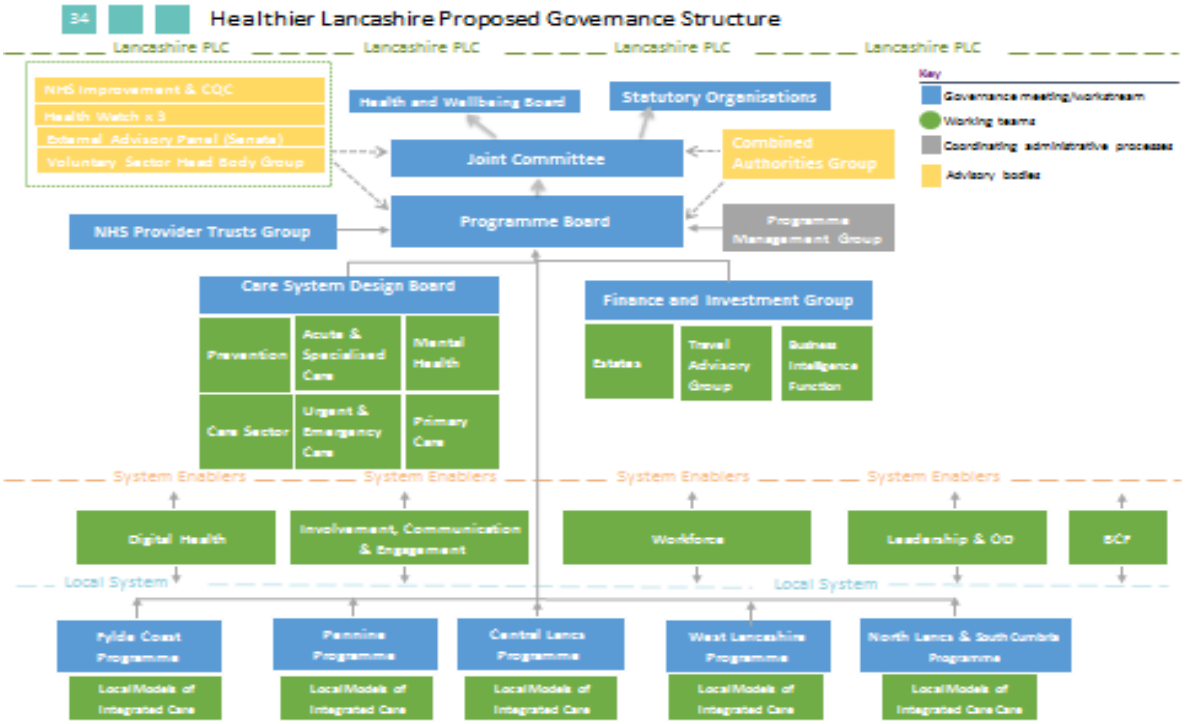
2.1. NHS and local government organisations across Lancashire have committed to working effectively together to take forward the transformation of services within available resources as set out in the 5 Year Forward View. They are aware of the development devolution agenda nationally and intend to be well placed for local

opportunities that may bring. This commitment is being taken forward through the Healthier Lancashire Programme, supported by a strategic change management team and programme management office.

2.2. To ensure this complex transformation process is undertaken effectively and efficiently. Healthier Lancashire is looking forward to ensure the necessary processes and expert advice is in place at every step of the journey.

2.3. The Lancashire Health and Care System is moving from agreeing the arrangements to putting them in place, in readiness for major programmes coming forward.

2.4. The diagram below sets out the proposed governance structure. This has been finalised following the events in November 2015 and comments received from organisations following the reports of those events. Further amendments have been made from meetings of the Interim Steering Group, Transformation Executive Group, Collaborative Commissioning Board and a variety of other meetings and one to one discussions.



2.5. It seeks to confirm the desire for a federation model, through collaborative leadership and through consistent approaches and agreed principles, based on a shared purpose and utilising large scale change methodology and robust involvement of all stakeholders, including local politicians and the public.

2.6. The slide deck (slides 44-47) contain the high level terms of reference for each element of the structure.

2.7. The Lancashire health and care system has over the last 18 months of working together recognised and actively supported the need to call on expert advice and

expertise from a number of sources, both internal to the system, but also external. This has been based on a further agreed principle to put the best people on the Programme to ensure success. Therefore the requisite legal advice supporting the development of the Healthier Lancashire structures has been provided by Capsticks LLP. Local systems are also seeking legal advice on their arrangements from a variety of legal firms.

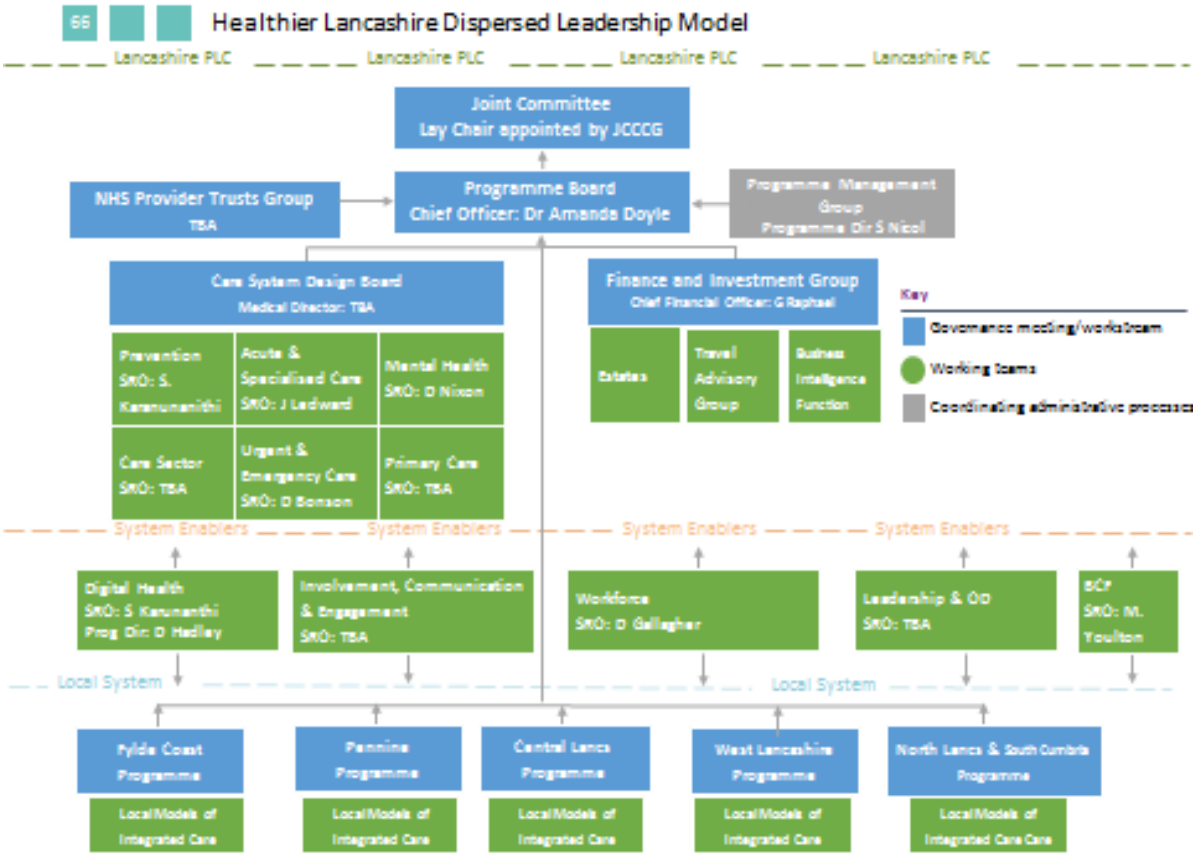
2.8. There is a process underway to establish the Joint Committee of Clinical Commissioning Groups as this involves the agreement by each CCG on the functions that will be delegated and how assurance will be provided to each CCG. This is being led by Dr Amanda Doyle and supported by Gerard Hanratty from Capsticks LLP. It is hoped that this will be established by the end of April.

2.9. There are still discussions continuing in relation to the establishment of a single Health and Wellbeing Board for Lancashire and to a Joint Overview and Scrutiny Committee. The conclusion of these discussions and any new terms of reference for these bodies will obviously have an impact on how the Joint Committee of Clinical Commissioning Groups relates to the Health and Wellbeing Board and its role in system leadership and accountability. The future state however, is represented in the illustration.

2.10. In order to mobilise the supporting programme structure there has been a lot of work at local health and care economy levels to ensure their arrangements mirror Healthier Lancashire and following the establishment of the Joint Committee these will be reviewed and aligned as necessary.

2.11. To support pace of mobilisation a dispersed leadership model has been proposed. This is shown in the diagram below. Leadership of change at this scale and speed will be shaped by dealing with emergence, the need to influence rather than control and the importance of working through distributed leadership to align multi-faceted changes.

2.12. This dispersed leadership model builds on the commitment made on 19th November and set out above at paragraph 1.2.1. Dr Amanda Doyle was nominated and has been supported to undertake the senior responsible officer role and to be known as the Chief Officer. In addition Gary Raphael has been supported by the CCGs to undertake the role of Healthier Lancashire's Chief Finance Officer full-time. This has necessitated a shared Chief Finance Officer post with Fylde and Wyre CCG. High level role descriptions are included at slides 54-61.



2.13. There are however, a number of leadership roles left to fill and to ensure securing the right person a variety of recruitment methods will be used; these include:

2.13.1. Joint Committee – Lay Chairman: expressions of interest to be sought from existing CCG lay members and a recruitment process to be undertaken

2.13.2. Medical Director for Healthier Lancashire – NHS recruitment process

2.13.3. The Involvement and Communications Director for Healthier Lancashire – NHS recruitment process (this function is shown at slide xx and is described as a Communications and Engagement Director)

2.13.4. Primary Care – expressions of interest to be sought for a senior responsible officer and also for a clinical lead

2.13.5. In respect of the Care Sector Work Stream, Prevention Work Stream and the Workforce Group discussions are ongoing to confirm either proposed nominations or agreement to look for expressions of interest.

2.14. While the green boxes are being referred to as work streams it should be noted that wherever possible existing groups are being used. For instance the Prevention Work Stream will be led and co-ordinated through the Public Health Collaborative, which is chaired by Dominic Harrison, the Director of Public Health for Blackburn with Darwen, but which includes the Directors of Public Health from Lancashire and Cumbria and Public Health England and other colleagues. The Healthier Lancashire (and Sustainability and Transformation Plan) lead from this group is Sakthi Karunanathi, Director of Public Health Lancashire County Council. Again for the Urgent and Emergency Care Work Stream, this will be the existing Lancashire and

South Cumbria Urgent and Emergency Care Network, which is led by David Bonson and supported by managers from the Commissioning Support Unit.

2.15. Other posts, such as the programme management office and programme managers to support the senior responsible officers and the work streams will be secured through discussions between the CCGs and the Commissioning Support Unit and a redefining of their existing contract, but also consideration of backfill of posts to release people from across the system and then where necessary an NHS recruitment process.

2.16. In committing to the arrangements outlined then organisations are also committing to supporting its mobilisation through financial means or in kind, by releasing clinical and managerial staff to participate in their local programmes of work and in the collaborations at the Healthier Lancashire level too.

2.17. The resource plan and suggested funding model have been developed based on evidence of other large scale change programmes around the country, adapted to fit the Healthier Lancashire structure and reflecting the existing arrangements and co-designed by the members of the Lancashire Finance Network. This is subject to a final discussion and recommendation by the Finance Network on 4th March and then will be presented to organisations through their directors of finance/chief finance officers.

3. Conclusion

3.1. In order to ensure the successful completion of the Strategic Planning Phase and to mobilise quickly, as agreed at the Executive Leadership Summit on 19th November 2015, organisations must now confirm their understanding and agreement to the proposed governance and programme structures.

3.2. There are still a number of leadership roles to fill, but there are processes outlined to ensure these are recruited to.

3.3. The resource plan and funding model underpinning these arrangements is still being considered and will be brought back to each organisation through their financial leaders.

3.4. There are still further steps to be undertaken and specialist support, legal and involvement and communications expertise will be required to move from agreeing the arrangements to putting them in place with a coherent integrated operational model.

4. Recommendations

4.1. Lancashire Leadership Forum, Collaborative Commissioning Board members and Lancashire Transformation Executive Group members are asked to:

4.1.1. Note the contents of this report and include it as an item for discussion across their Board/Governing Body/Senior Management Team meetings during March 2016.

4.1.2. Ensure that this paper and appended slide deck are included as an agenda item at their March 2016 Board; Governing Body or Senior Management Team meetings. The paper is for discussion in the private part of these meetings.

4.1.3. Seek the agreement to the governance and programme arrangements for Healthier Lancashire and confirm their commitment to working within these.

4.1.4. Note the proposals for filling the gaps in the dispersed leadership model and support colleagues, from within their organisations, to come forward and express their interest in the roles.

4.1.5. Assure their governing bodies and boards that a final paper for public meetings will be provided for April.

5. Next Steps

The next steps are set out based on the identified dependencies and aligned to the Healthier Lancashire plan's critical path.

- Enact the processes to fill the vacant leadership roles
- Establish the Joint Committee and Programme Board and supporting structure
    - Terms of reference
    - Decision making authority
    - Membership
    - Interfaces to be managed
    - Information flows
- Align Healthier Lancashire and Local Health and Care Economy governance and programme arrangements
- Agree the Resource Plan and Funding Model.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Scott Butterfield, Corporate Development and Research Manager
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	20 April 2016

DRAFT FORWARD PLAN

1.0 Purpose of the report:

1.1 To inform the Health and Wellbeing Board members of the draft Forward Plan that has been developed for the Board.

2.0 Recommendation(s):

2.1 That members of the Board consider the draft Forward Plan and advise of any forthcoming initiatives, projects, policy developments and any other agenda items from individual organisations that are of interest to and are the business of the Board.

3.0 Reasons for recommendation(s):

3.1 In order to maintain a strategic oversight of the health and wellbeing agenda and ensure that the Board fulfils its statutory duties, a draft Forward Plan has been developed. This will enable the Board to strategically plan its future agendas and ensure that items are aligned to and relevant to the delivery of the Board's priorities.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increasing resilience."

5.0 Background Information

5.1 In order to maintain a strategic oversight of the health and wellbeing agenda and ensure that the Board fulfils its statutory duties, a draft Forward Plan has been developed. This will enable the Board to strategically plan its future agendas and ensure that items are aligned to and relevant to the delivery of the Board's priorities. This plan was agreed at the meeting of the Board held on the 15 July 2015 and has been reviewed at all meetings since then and it is intended that it will be reviewed at all future meetings to give the Board oversight of its workplan.

5.2 At the Strategic Commissioning Group away day on 1 July 2015, the link between the Health and Wellbeing Board and Strategic Commissioning Group was discussed. In order to maintain the relationship between the Board and Strategic Commissioning Group, and ensure that there is alignment between the Strategic Commissioning Group's commissioning priorities and the Board's strategic priorities, the draft Forward Plan will be included as a standing item at the Strategic Commissioning Group to enable relevant items from the Strategic Commissioning Group to be added on a regular basis for discussion and ratification.

5.3 Does the information submitted include any exempt information? No

5.4 **List of Appendices:**

Appendix 8a – Draft Forward Plan

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

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Appendix 8a

(Draft) Health and Wellbeing Board Forward Plan 2015 – 16

BOARD MEETING	BOARD	BUSINESS ITEMS	THEMED DEBATE	DEADLINE FOR REPORTS
Wednesday 8 June 2016 3.00 – 5.00pm	Formal	**SUB-GROUP UPDATES** 1. Strategic Commissioning Group update (15mins) **BUSINESS ITEMS** 2. Governance (15mins) 3. Combined Authority (20mins) 4. HWB Strategy approval (15mins) 5. Alcohol Strategy (15mins) 6. Fylde Coast Cancer Strategy (15mins)	Healthier Lancashire and NHS Sustainability and Transformation Plan (30mins)	All finalised reports to be sent to Venessa Beckett by **12 noon on Wednesday 25 May 2016**

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